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September, 1941

BULLETIN OF THE MENNINGER CLINIC

VOLUME 5

NUMBER 5

TOPEKA

KANSAS

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MILITARY PSYCHIATRY NUMBER

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Issued bi-monthly by THE MENNINGER CLINIC, TOPEKA, KANSAS
Volumes begin with the January number. Annual subscription rate, $2.00.
Single numbers, 50¢.

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Bulletin of
THE MENNINGER CLINIC

VOLUME 5 SEPTEMBER, 1941 NUMBER 5

EXPLANATORY NOTE

The experiences of World War I brought about a great awakening in regard to the essential function psychiatry should have in helping to select men for the armed forces and in treating individuals who become mentally ill during the stress of training and actual combat. Since the Armistice the government has expended about one billion dollars in the compensation and hospital care of those enlistees and draftees who became neuropsychiatric casualties, many of whom could have been detected and excluded by adequate psychiatric examination.

In the period between the first world war and the present emergency psychiatry as a profession has developed tremendously, not only in the number of trained psychiatrists but in the deeper knowledge of etiology, examinational methods and treatment procedures. However, the medical profession and the general public have not kept pace with this expansion of psychiatric knowledge. This is illustrated by the apathy which many medical examining boards have had toward the acute need for adequate psychiatric examination of all registrants so that the armed forces will be spared the futile attempt to make fighting men out of ill-adapted material and the taxpayers will be spared the enormous cost of taking care of those who develop psychiatric disorders after being inducted. An heroic attempt is being made by Dr. Harry Stack Sullivan, Consultant on Psychiatry to the Selective Service System, to impress the medical examiners and psychiatrists with the urgency of the need for proper psychiatric examination of all registrants, and under his leadership seminars for practical psychiatric diagnosis have been organized and held in many cities during the past seven months. Several members of the staff of the Menninger Clinic have attended and participated in these seminars.

In order to inform ourselves with regard to the various aspects of military psychiatry, the staff of the Menninger Clinic organized and conducted during the week of June 23-28 a series of seminars on the function of psychiatry in the present emergency. Particular em-

phasis was laid on the most acute need at the present time—the adequate psychiatric examination of registrants, but seminars on treatment methods and on the possible contributions of psychiatry to the problems of civilian morale, propaganda, and the rejected registrant were also included. Open discussion of these various problems with the lay board members, medical examiners, and social workers who attended the seminars, together with inspection of and participation in local board and induction board examinations, led to some conclusions and suggestions for further education of medical examiners and the general public. To that end the essential material of these seminars has been assembled in the papers herein published.

The presentation of the seminars and the publication of this number of the BULLETIN were made possible by a grant-in-aid from the Menninger Foundation with the avowed hope of disseminating knowledge of the contributions psychiatry can make and the functions it can assume in the present national emergency.

THE EDITORS.

OBJECTIVES OF THE SELECTIVE SERVICE PSYCHIATRIC CLASSIFICATION

By Douglass W. Orr, M.D.

The function of the psychiatrist in the Selective Service System has been officially described as being: (1) to exclude unsuitable candidates from among the registrants sent to the Army Induction Boards, and (2) to protect rejected candidates, on the one hand, and general civilian morale on the other, from damage in the process of psychiatric classification. It is therefore pertinent to ask two questions about this task that has been assigned to the psychiatrist: First, why is the process of psychiatric classification considered so important? Second, how is the classification supposed to work?

The importance of this task is indicated by the lessons of World War I. With inadequate psychiatric examinations in 1917–1918, too many mentally ill or otherwise maladjusted men got into the army; such cases caused great damage to army morale and occupied too many hospital beds needed for other purposes; and the treatment and compensation of such cases have since cost the taxpayers large sums of money, an estimated $35,000 per case.* Line officers, medical officers, Veterans Bureau officials, and taxpayers alike have a stake in preventing a repetition of the mistakes of the last war.

Furthermore, it is impossible to estimate statistically the damage done to army morale when a soldier develops a neuropsychiatric disorder. Certainly it is not only the man who reacts with a neurosis or psychosis to the stresses of training or warfare, who disrupts the morale

* Three-fifths of the beds in our 79 Veteran's Hospitals are, at the present time, occupied by neuropsychiatric patients, a total of some 33,000; and 4,800 more are expected each year. Between 1923 and 1940, $641,857,704 was paid in compensation and $282,679,909 was spent for the hospital care of neuropsychiatric cases: a total of nearly one billion dollars. In the fiscal year ending June 30, 1940, nearly 22 years after the Armistice, the government paid out *in compensation for neuropsychiatric cases only* $41,889,360 to 68,727 men, 35,846 of whom are diagnosed "psychoneurosis" or "neurosis." It has been calculated that each neuropsychiatric casualty of World War I has cost the tax-payers about $35,000. If past experience is a guide, then, every three potential neuropsychiatric casualties among present registrants who are detected and rejected will save $100,000 over the next twenty years.

of his platoon or company; just as often it is the man whose reactions to army discipline or to the vicissitudes of army life make him a chronic trouble-maker, a malcontent, an alcoholic, or a generally unreliable person. The army personnel cannot afford to waste equipment and training time upon selectees who become neuropsychiatric casualties.

The Local Board medical examiners, in addition to excluding registrants for physical defects and diseases, should reject outspoken cases of psychopathology or refer doubtful cases to the Medical Advisory Board. Medical Circular No. 1 (Revised) of the Selective Service System* lists the diagnostic groups to be used. The original circular (published in the J. A. M. A., May 3, 1941) should be consulted for details, but in general the groups are as follows:

Group I.	Mental defect or deficiency, especially as revealed in slowness or stupidity in complying with clear orders.
Group II.	Psychopathic personalities.
Group III.	Manic-depressive personalities, especially those with history of hospitalization.
Group IV.	Psychoneuroses, including psychosomatic conditions.
Group V.	Schizophrenics, including pre- and post-schizophrenic states and all paranoid personalities.
Group VI.	Chronic alcoholic or other drug addicts.
Group VII.	Syphilis of the central nervous system in any form and of any degree.
Group VIII.	Organic diseases of the brain, spinal cord, or peripheral nerves, including the epilepsies.

Registrants who fall into any of these eight groups are to be rejected. Doubtful cases are to be referred to the psychiatrist of the Medical Advisory Board. From this it is clear that the principal task of Local Board examiners and Medical Advisory Board psychiatrists is primarily that of rejection on the basis of existing, manifest neurological or psychiatric pathology.

Psychiatrists attached to Army Induction Boards are being given a much more difficult task. With the more obviously psychopathic men eliminated, they are asked to eliminate further: (1) those men with more subtle personality disorders missed by previous examiners;

* Journal of the American Medical Association; 116:2059–2061; May 3, 1941.

(2) men whose present personality make-up suggests that they *may* break under the special stresses and strains of camp life; and, even beyond these, (3) men who may be expected to develop some type of neuropsychiatric disorder at any time during the next eleven years, the period of camp training plus the period of liability to military service as a member of the organized reserve. It is even suggested that the Induction Board psychiatrists should endeavor to pass only men who are, in a positive sense, "vocationally suitable" for army life, rejecting all those who, in no sense mentally ill, are nevertheless better adjusted to civilian jobs than they could ever be in the Army.

The official suggestion that the Selective Service System psychiatrist is responsible for the morale of the rejected registrant and of the community at large has been variously interpreted. Recent discussions of this question have emphasized the importance of informing the community fully about the psychiatric classification and the reasons for it, and of stressing the point that rejection by the psychiatrist is no disgrace, whether because the rejected registrant does have some kind of neuropsychiatric disorder or simply because his personality and type of adjustment in civilian life make him "vocationally unfit" for the Army. Beyond this, protection of the rejected man depends upon (a) the manner in which he is informed of the reasons for rejection; (b) some sort of follow-up, with suggestions as to where to obtain treatment, if needed; (c) how the rejection is interpreted to the registrant's family and neighbors; and so on. Certainly an example of what *not* to do is to be found in the article by Walter Davenport in a recent number of Collier's in which it is clearly implied, it seems to me, that the only purpose of Selective Service System psychiatrists is to weed out "crazies," "madmen," "screwballs," and "slap-happy Harrys." This sort of attitude may serve to protect the Army, but can only injure the rejected man and his family. It has been suggested that considerable misunderstanding might be avoided if the term "vocational classification" could be substituted for "psychiatric classification." As matters stand, however, there is an urgent need for greater emphasis upon the second aspect of the psychiatrist's mission in the Selective Service System: protection of the rejected registrant and of general civilian morale from the consequences of rejection for neuropsychiatric disorders.

THE PSYCHIATRIST IN RELATION TO THE EXAMINING BOARDS

By William C. Menninger, M.D., and Edward D. Greenwood, M.D.

The Selective Service Medical Examining Board in the community and the Induction Board located in an army mobilization center both have as their function the selection of the physically and mentally fit registrants for service in our armed forces. In the Selective Service Examining Board the examiners are practicing physicians in the community who volunteer their services; theoretically the time required to make the examination is not limited, and the psychiatrist examines only those individuals who are especially referred to him. The Medical Advisory Board consists of specialists serving as adjuncts to the Medical Examining Boards. The Induction Board, on the other hand, is composed chiefly of Army physicians, the time utilized for examination is at a great premium, and the psychiatrist is a regular member of the examining team.

One of us (W. C. M.) is an advisory board psychiatrist to the three local Draft Examining Boards; the other of us (E. D. G.) has served as the psychiatrist on an Induction Board.

THE ADVISORY BOARD PSYCHIATRIST

In theory the Medical Advisory Board of Specialists constitutes a strong support for the regular Examining Board. As far as the psychiatrist is concerned, there are many flaws in the actual operation of the system. In the first place, the physician listed as a "psychiatrist" on the roster of the Medical Advisory Board apparently may or may not be in the practice of psychiatry. In seven of the seventeen boards of the Kansas districts, for example, these men are not in the practice of psychiatry, and in several other districts the advisory board psychiatrist lives from fifty to two hundred miles from the local draft board, and consequently is apt to be little used.

In the second place, the only neuropsychiatric procedures included on the regular physical examination blank (form 200) are limited to one line under the heading "Nervous System" and refer only to neuro-

logical data (the pupillary and patellar reflexes). The evidences of personality disorders as well as of many neurological conditions are given no place in the present report form.

A third major difficulty in the set-up of the Examining Board of Physicians is that, since they are unpaid volunteers, to save time they usually organize themselves to function as an "assembly line" and no one is responsible for the neuropsychiatric examination.

Finally, even when available, the examining board psychiatrist is rarely used, presumably because many examining physicians are unaware of the importance of neuropsychiatric difficulties.

These four difficulties—the lack of a psychiatrist in the examining group, the lack of specific instructions for inquiry into the neuropsychiatric difficulties, the lack of responsibility for the neuropsychiatric examination and the failure to realize its importance—lead to the lamentable result that most of our draftees are given no adequate neuropsychiatric evaluation.

In those situations where the medical examiners are sufficiently interested and cooperative, the Advisory Board psychiatrist may be able to present to Local Board physicians the facts regarding the importance of the neuropsychiatric examination and suggest the technique for the detection of such disorders, or he might sit in as one of the team members of the examining group.

In addition to emphasizing the cost of the neuropsychiatric casualties, the Advisory Board psychiatrists might very helpfully point out to the examining physicians certain prevalent erroneous attitudes among the laity and even among some examining physicians. The first of these attitudes is expressed about as follows: "I've known that lad all of his life. He has always been queer, and there is no reason why he can't serve in the Army." Aside from the fact that the Army doesn't want "queer" soldiers, every psychiatrist knows that queerness itself indicates a precarious adjustment and may be a very good reason for not subjecting such an individual to the stress of Army life.

A second undesirable attitude is expressed with some emotion by the draft board physician when he says of a registrant: "He's just putting that on to escape his duty." In such cases one's social indignation may be justifiably aroused, but psychiatric judgment indicates that such an individual may be seriously maladjusted and military experience tells us that the Army does not want that type. A similar

attitude is shown in the anger of a draft board examiner towards a registrant who has had his teeth pulled to evade the service. Our Army today does not include labor battalions and as a consequence every man has a varied round of duty. Any individual who would have his teeth extracted to evade Army service almost guarantees that he will be a misfit in the army situation.

A fourth erroneous attitude is expressed in the statement, "He is a bit run down, and Army life will build him up." This may be true, but Army physicians as well as line officers protest against regarding the Army as a "health resort."

Last, and perhaps most common, is the attitude that a man can be sent to the Army as a place to learn discipline. One needs to keep in mind that we are attempting to build an intelligent and dependable soldier as a unit in the defense of our homes. It is short-sighted, as well as incorrect, to assume that our military organizations are going to serve as correctional institutions.

The Advisory Board psychiatrist could helpfully present to the regular draft board examiners the symptoms, signs and the personality traits typical of character disorders in the early stages. (These are included in other presentations of this seminar.) He might advisably present a brief outline of such an examination which any physician could follow. Since in the draft board examination time is not an important element, at least fifteen minutes spent with each registrant would eliminate a large proportion of the psychological and neurological misfits. The use of a report form is a matter of individual preference, but past experience indicates that the absence from the physical examination report of any notations of disability leaves no other conclusion than that the abnormality was not present at the time of the examination and throws legal liability upon the government.

Under the present regulations, the psychiatric Advisory Board specialist sees only those exceptional cases referred to him. There are no time limitations. It is most practical to arrange for a private appointment with the registrant. Observation of the individual's total response to the situation furnishes extremely valuable data, and almost all reports of advisory board psychiatrists indicate the advisability of using a neurological examination as the vehicle for the psychiatric evaluation. As noted in the examination outline presented elsewhere,

various fields of investigation are included: education, occupation, family and social history, behavior disorders, and psycho-somatic complaints. It is extremely important to point out that a great majority of most serious psychiatric syndromes are detectable only through historical evidence and psychological examination.

THE INDUCTION BOARD PSYCHIATRIST

As a member of the examining team at the Induction Center, the psychiatrist sees every registrant. At the present time, under ideal conditions, three to five minutes are allowed for making a personality investigation and a neurological examination. In the experience of one of the writers, 273 registrants were examined in three days, *none* of whom had previously been seen by a psychiatrist. The examiner is further handicapped because no historical information is available about the registrant. At out nearest Induction Center, the psychiatrist was the last man in the assembly line, with the result that if he took more than two minutes per registrant, a "bottle-neck" was produced in the examining process. Recently the procedure has been changed so that the psychiatrists are at the beginning of the line, and thus more or less pace the rate of sending the men through for examination.

It is evident that the lack of historical information and the necessity to do a psychological and neurological examination and to arrive at a diagnosis in three to four minutes make the work of the Induction Board psychiatrist highly unsatisfactory. The result must be that he can catch only the very obvious disorders and that his decisions must be largely "hunches" and "guesses."

It is exceedingly desirable that the psychiatrist be furnished an adequate history of the individual. This, if necessary, might be obtained by trained social workers, and could be along the general lines of the neuropsychiatric examination presented in the next paper. It would also seem to us that a neurologist should be obtained to carry out the neurological examinations. A third recommendation would be to have a system by which the various examining physicians along the line would indicate suggestions and observations which would be helpful to the psychiatrist; for example, the physician who examine the heart could indicate neurotic anxiety or tachycardia which he observed. A further suggestion is that if the registrant is to be refused admission to the Army because of neuropsychiatric diffi-

culties, the psychiatrist should explain the reason for this to the registrant in terms likely to spare him trauma. Keeping in mind the extreme importance of the individual's morale, the psychiatrist by virtue of his training should be best fitted for this job. He may even have occasion to suggest some other type of work in the present emergency for which the individual is better fitted.

To summarize, the Advisory Board psychiatrist and the Induction Board psychiatrist have tremendous responsibilities but are functioning against what appear to be unnecessary handicaps. At present the importance of the neuropsychiatric examination is either unappreciated, unknown, or ignored. Under the present set-up no one on the regular examining board has the function of evaluating the individual as a total fighting unit. In consideration of this fact, it is desirable that the Advisory Board psychiatrist present as much information as possible about past experience with the neuropsychiatric casualties to the examining board, that he present the neuropsychiatric point of view of evaluating the individual as a total unit, and that he outline a technique to detect such difficulties. In the case of the Induction Board psychiatrist several recommendations have been made. If we accept the importance of the neuropsychiatric examinations, such comparatively trivial obstacles as red tape, lack of time, distance, or lack of psychiatrists *must be* surmounted.

ABBREVIATED NEUROPSYCHIATRIC EXAMINATION FOR USE IN SELECTIVE SERVICE EXAMINATIONS*

By William C. Menninger, M.D.

The necessity for a condensed neuropsychiatric examination for use by the Selective Service Board examiners and the Advisory Board psychiatrists presents a *very* special problem. Because of the shortage of psychiatrists, the great numbers of men to be examined and the necessity for swift action, the neuropsychiatric examination of registrants is greatly handicapped by the time limitation. For the Induction Boards this is now theoretically three minutes, and for the Selective Service Boards, fifteen minutes. For the examination of registrants referred by the Selective Service Board, the psychiatrist may devote as much time as he himself wishes to give.

For the practical use of the members of examining boards, most of which are composed of general practitioners and general medical men, the following outline and guide are presented as suggestions. A report form also is appended which may be used at the discretion of the examiner. It is of major importance to know that unless the original physical (and neuropsychiatric) examination records show a notation of any disability which is present, the government has no recourse in the event of later claim by the soldier, even though the disability may have existed at the time of induction; hence a report form is an additional safeguard.

The suggestions given here cover both historical and examinational procedures that may be used as a method of conducting the neuro-

* Also presented at the Seminar on Practical Psychiatric Diagnosis for Psychiatrists of Medical Advisory Boards and Army Induction Boards, Dallas, Texas, June 16–17, 1941 and to appear with more complete discussion in an early issue of *War Medicine* (A.M.A. Press). A suggested neuropsychiatric examination report form was recently sent out from various Corps Area Headquarters, which in every detail is the same as that presented by Aita (Aita, J. A.: The Problem of Neurologic and Psychiatric Examination during Military Mobilization. *Proc. Staff Meet. Mayo Clinic*, 16: 283–287, 294–98, 307–13, Apr. 30, May 7, May 14, 1941). The present recommended form includes many additional points of investigation and covers the 8 psychiatric classifications of Sullivan (Sullivan, H. S.: Minimum Psychiatric Inspection, Medical Circular No. 1, revised. *J. A. M. A.*, 116: 2059–2061, May 3, 1941).

psychiatric evaluation of the registrant. The general headings as well as the specific suggestions regarding questions follow in consecutive order the recommended report blank which follows.

Much of the interrogation can be carried on simultaneously with the neurological examination suggested below. In no instance can the examiner assume that this or any other outline can be used in a stereotyped manner. It is to be regarded as suggestive of subjects to cover and as a technique for doing so, to be utilized as he wishes by the Advisory Board psychiatrist or by any member of the examining board to whom this responsibility is assigned.

1. EDUCATION: *Under this heading one should attempt to determine the registrant's intellectual capacity and achievement, his attitudes toward education and his adjustment to school life.*

How far did you go in school? Did you have any special training in vocational or business school? How old were you when you stopped school? What was the reason for your stopping school? (Here the registrant may report that he had to stop because of finances, that school was not interesting to him, that his family did not insist that he continue, or the examiner may learn that he was expelled from school.) What kind of school work did you do: average, above average, below average? Did you ever play hookey or cut school? Were you ever put out of school for any reason? When? Why?

2. OCCUPATIONAL HISTORY: *In this field the examiner should determine the registrant's stability as indicated in his adjustment to work, his attitude towards work, his relationship to superiors, fellow workers and his employees, also his tendency to dependency or independence and his attitude toward these states, his ambitiousness, indifference, shiftlessness, truculence, etc.*

Are you working now? Is it a permanent or temporary job? How many jobs have you held since you left school? What is the longest time you have ever held one job? How much of the time since you have been out of school have you been employed? How have you liked your various jobs? Have you gotten any advancements? Have you had to support any member of your family? When you weren't working who supported you?

3. FAMILY HISTORY: *Of the 9 general headings this is perhaps least important but the examiner can get clues as to conditions which may or may not have had an important influence on the registrant's constitution and life.*

Did anyone in your family ever have fits, convulsions, epilepsy? Were any of them nervous or did any of them ever have a nervous breakdown? Were any of them ever mentally sick or crazy? Were any of them ever in mental hospitals or asylums? Did any of your relatives ever drink too much? Did any of them ever commit suicide or try to kill themselves? Were any close relatives ever in jail? Why?

4. CHILDHOOD HOME ENVIRONMENT: *The examiner should attempt to judge the early environmental influences in the registrant's development, particularly emotionally traumatic experiences, his adjustment to those living intimately with him.*

With whom do you live now? When did you leave your childhood home? Why

did you leave it? Do you think you had a happy childhood? (If not, what was wrong with your home?) Did your family move around much? Did your parents get along well together? How did you get along with them? With your brothers and sisters?

5. Social Relationships: *Under this heading one can determine the registrant's social or antisocial attitudes, his capacities and abilities to get along with people, and his capacity for finding satisfactory outlets and interests.*

Have you been married? Separated? Divorced? Does your wife work away from home? (through preference or necessity?) If unmarried, how often do you "date" girls? *Attitude towards people:* Do you have many friends? Do you like to go to parties? Do you think you are sociable, or do you prefer to be alone? Have you ever felt that your family or your friends didn't like you? Did you ever feel that people treated you unfairly—your boss, your friends or your family? Did you ever have the feeling that you had some enemies who were working against you or trying to trick you, or make trouble for you? *Hobbies and Recreation:* What have been your interests outside your work? Do you like sports? Like to make things out of wood, metal? Did you ever collect anything—stamps, coins, minerals? Do you like to hunt or fish? *Sexual Life:* Did you ever have a venereal disease? How is your sexual power? (The examiner may want to go further if he has any leads to inquire as to the concern or attitude toward masturbation and homosexuality.)

6. Physical Complaints and Disorders: *The examiner can often get clues as to functional somatic disorders and thus to neurotic tendencies, in addition to inconspicuous or early organic disease.*

Did you ever have any trouble with urinating at night while you were asleep? Have you ever been nervous? If so, how? Did you ever have a nervous breakdown? Have you ever had a fit, or a convulsion? Did you ever lose consciousness? Do you sleep well? Have you ever had any injuries or blows to your head or back? Have you ever had "brain inflammation" of any sort? Did you ever faint? Under what circumstances?

Have you ever had pains, aches, or weak spells? Do you ever have headaches? Have you ever had dizzy attacks? Did you ever have a weakness or paralysis of one arm, one leg, or one side of your body? Do you ever have funny sensations of your skin, like numbness or tingling? Do you ever get the "shakes," or spasms? Do your muscles ever twitch? Did you ever have any marked change in your weight, 20 or 30 pounds in a short time? Are you ever subject to temper outbursts? Do you suddenly get so mad you don't know what you're doing? Do you ever have much change in your mood: Are you gay sometimes and down in the dumps at other times? Can you "snap out of it"? Do you get moody or blue easily or very often? Do you feel so discouraged that you don't care whether you keep on or not? Have you ever had periods when you felt over-stimulated or too excited? (It is extremely important to determine whether the registrant is of cyclothymic disposition, and if so, to establish the degree and extent of his instability.)

Do you have any trouble sleeping? Do you have periods when you can't sleep? What do you do about it? Do you get tired more easily than you think you should? Have you ever taken medicines for anything—laxatives, something to help you sleep, or nerve medicine? Do you have any difficulties that come and go, with your stomach, your sinuses, or your heart?

(Does the registrant give any evidence of hypopituitarism? Obesity, somnolence, under-developed genitals. Any symptoms of hyperpituitarism? Large, coarse features, big hands, big feet, headaches. Does he indicate any obvious thyroid disturbance? Enlargement of thyroid, exophthalmus, tremor.)

7. Behavior Disorders: *In this field the examiner should learn of the registrant's capacity to abide by social customs and legal statutes, and learn of the presence of aggressiveness which may be turned against external authority or self-directed.*

Have you ever gotten into any kind of serious jams with the law? Have you ever been arrested? How much do you drink? Do you ever get the "shakes," or the "D. T.'s"? Have you ever had any serious car accidents? How many of them? Industrial accidents? Did you ever run off from home? Why?

8. Attitude towards Entering the Service: *The physician should judge in some degree from the registrant's remarks and behavior his conscious willingness or unwillingness, and thus his attitude regarding cooperation in military service.*

How do you feel about getting into the military service? (Here the registrant may explain that he has a job which he doesn't want to give up; he may facetiously remark that he has other plans and hopes the doctor will "find something wrong with him," but almost surely he will express some opinion as to his fears or interests or disinclination.)

9. General Intelligence: There are several accurate intelligence tests, but the examiner here has no time to give these, nor has he an opportunity in most instances to question the registrant about his general information or his ability to use this information. Consequently, the estimation of intelligence must be pretty largely on the basis of the examiner's impression. In many instances this is enough for all practical purposes, and this can be indicated in the very rough classification of Superior, High Average, Average, Low Average, Borderline, or Subnormal. In case of doubt the individual should be referred for a psychometric examination by a psychologist.

NEUROLOGICAL EXAMINATION*

Many neurological observations as well as many pertinent questions relative to the neurological status have been suggested in the psychiatric examination as given above. In addition there are also the data available from the other medical examiners with regard to the eyes, the ears, the orthopedic examination, as well as the general musculature, the body build and coordination. Much of the psychiatric examination can be carried on simultaneously with the neurological examination. As in the case of the psychiatric examination, in the event of significant positive findings, the suggestions given here are too superficial. For a complete neurological examination one must refer to standard textbooks in the field.

* The procedure suggested here will take approximately two minutes. A somewhat more careful and comprehensive examination is presented in a later paper in this issue.

1. *Motor Functions:* The gait can often be observed adequately when the registrant enters the examiner's office. It is wise to have the registrant walk on his toes, hop on each foot, and stop suddenly. The Romberg sign is tested by having the man stand upright with his eyes closed, putting the heels and toes together; the extent of any weaving or tendency to fall over indicates that this sign is positive in varying degrees. If he consistently has to catch his balance by moving one foot, the Romberg should be marked as 4 plus. The examiner should note the motor performance, specifically the strength, the presence of tremor, the status of muscular tonus and the presence of muscular atrophy.

2. *Reflexes:* The registrant should sit on a table at which time it is a simple matter to test the biceps, the kneejerks, the Achilles tendons, and the plantar reflexes. Others occasionally need to be examined.

3. *Sensation:* Unless the registrant complains of numbness or gives some evidence of anesthesias or paresthesias it is sufficient for the examiner to test the coordination, as demonstrated by extending the arm full length and with the eyes closed to touch the tip of the nose with the tip of the index finger. This is primarily a coordination (cerebellar) test, which is a combination of motor and sensory functions.

4. *Cranial Nerves:* Notation is made of strabismus (cross-eyedness in one or both eyes); nystagmus in one or both eyes and the type and direction; deviation of the tongue from the midline on protrusion, and facial weakness or asymmetry.

The examiner may if he wishes have the registrant repeat any test phrases to examine his speech. In the conversation prior to this time it is probable that any conspicuous disturbances of speech will have already been noticed.

REPORT FORM FOR NEUROPSYCHIATRIC EXAMINATION

NAME..... Age..... Number.....

READ CAREFULLY: Grade intensity of positive findings + to ++++ where possible. Fill in only positive material; put a "?" for questionable findings; otherwise leave spaces blank. Retain all blanks until end of day, then turn them in.

PSYCHIATRIC

1. EDUCATIONAL HISTORY: *Encircle last grade completed:* Grammar School 1 2 3 4 5 6 7 8th grade; High School 1 2 3 4; College 1 2 3 4; Professional, Vocational, Business. Age quit school.....; Reason: (economic, indifference, expulsion). Caliber of school work..... Truancy.....

2. Occupational History: At present has Permanent job, Temporary job, Unemployed. *Encircle approximate number of jobs held:* 1 2 3 4 5 6 7 8 9 10 in last 1 2 3 4 5 6 7 8 9 10 or more years. Longest time on one job (*encircle*) ¼, ½, 1 2 3 4 5 6 7 8 9 10 15 20 years. Rough per cent of adult life unemployed (*encircle*) 5 10 25 35 50 75 90 100%.
Examiner's impression of type of worker: .....
Examiner's impression of attitude toward work: .....

3. Family History: (State which relative) Epilepsy..... Psychosis.....
Alcoholism..... Suicide..... Psychoneurosis..... Nervous Breakdown..... Crime..... Other.....

4. Childhood Home Environment: (*Encircle*) Good, Fair, Questionable, Poor, Vagrancy, Nomadism: Severity (*Encircle*) 1 2 3 4 plus.

5. Social Relationships: *Marital Status:* Single, Married, Divorced, Widowed, Separated, Deserted.
Attitude toward People: (*Encircle*) Sociable, Seclusive, Retiring, Hostile, Suspicious, Eccentric. Hobbies and Recreation.....
Sexual Life: Fears, Worries, Venereal disease (*Encircle*) Syphilis, G. C.

6. Functional or Organic CNS Disorders: Enuresis..... Nervousness..... Breakdown..... Fits..... Sleeplessness..... Head or Back Injuries.....
Encephalitis..... Fainting.....
Signs and Symptoms (organic and functional) (*Check*)

Weak Spells.....	Tremor.....	Fatigue easily.....
Headaches.....	Marked Weight Change.....	Medicine, drugs.....
Dizziness.....	Temper Outbursts.....	(Functional) Organ complaints.....
Paralysis.....	Marked Mood Changes.....	Dyspituitarism.....
Paresthesia.....	Insomnia.....	Thyroid.....

7. Behavior Disorders: Arrests..... Alcohol habits (*encircle*) None, Slight, Moderate, Heavy, Excessive. Nomadism..... Accidents.....

8. Attitude toward Entering Service: (*Encircle*) Intent on avoiding; Prefers not to; Fears adjustment; Passively acceptable; Actively wishes to. Why?.....

9. Roughly Estimated Intelligence: (*Encircle*) Superior, High Average, Average, Low Average, Borderline, Subnormal.

10. General Impression of Fitness: (*Encircle*) Excellent, Good, Fair, Questionable, Poor.

Neurologic

1. Motor Functions: Gait: (*Check*) Normal.... Ataxic.... Spastic..... Steppage..... Limping..... Shuffling..... Propulsive..... Romberg: Amount of Sway (*Encircle*) 1 2 3 4 plus.
Musculature..... Strength..... Tremor..... Tonus..... Atrophy.....

2. REFLEXES

	Biceps		Abdominal		Knee		Archilles		Plantar		Others	
	R	L	R	L	R	L	R	L	R	L	R	L
Absent.....												
Sluggish.....												
Hyperactive....												

3. SENSATION: .....

4. CRANIAL: Strabismus R..... Nystagmus R..... Tongue Deviation R.....
L..... L..... L.....
Face weakness R .....
L.....
Speech: (*Encircle*) Normal, Aphasia, Dysarthria, Slurring, Scanning, Stammering.

SUMMARY

Qualified for military service .....
Disqualified because .....
Deferred because.....
Recommend.....

Examiner's Initials..... Date.....

DETECTING THE FEEBLE-MINDED REGISTRANT

By David Rapaport, Ph.D.

Mental deficients may be divided into three groups: idiots, imbeciles, and the feeble-minded or morons. The idiot cannot protect himself from danger and cannot express his biological needs or satisfy them by himself. The imbecile can be taught to perform certain routine functions, to contribute toward his maintenance, and to avoid simple danger situations, but cannot adapt himself to new situations or exist without constant support and supervision. The moron may earn his maintenance, may even for a period of time appear normal, but, being unable to profit by routine education, needs special-class instruction, and, lacking adaptivity, needs supervision.

It is probable that approximately twenty out of every thousand registrants are mental deficients. The probability* is that five of these are idiots or imbeciles, who may readily be recognized at the very first sentence uttered. Thus, the examining psychiatrist's real problem is to detect the remaining feeble-minded individuals (approximately fifteen per thousand registrants).

During the short time allotted for the psychiatric examination indications suggesting or excluding the necessity for further inquiry have to be found. Any successful high school work or an equivalent professional standing eliminates the necessity for such further inquiry. Lack of progress beyond grade school, failures, or interruptions due to lack of success make further investigation necessary. Of course, a reliable school history will furnish the ideal orienting data.

If further investigation is indicated, a progressively more detailed examination becomes necessary along several lines:

(1) *Physical signs.* The probable physical signs of mental deficiency are by no means unequivocal, so that the physician cannot rely upon them to detect more than a very small percentage of the feeble-minded.

* These estimates are crude and are based on the percentage of mental deficients in the total population, in all males and in those of draft age.

Observations of the size and form of the skull and actual measurements of circumference (norm 22 inches, margin 2 inches), if the skull is at all unusual, are useful. The following special forms are pathognomonic: oxycephalic (tower-shaped skull), scaphocephalic (keel-shaped), spherical (as in Mongolism), microcephalic, and hydrocephalic.[1] Next in importance are marked congenital malformations of the palate (saddle-shaped, V-shaped, cleft), jaws or teeth. Further suggestive signs are various developmental anomalies or deformities of fingers, toes, ear lobes or features—more generally, empty, sluggish, expressionless faces, which differ from those of schizophrenics, inasmuch as they are extremely stereotyped.

(2) *Functional examination.* Awkward posture, clumsy movements, defective coordination, speech defects, or responses that repeat the questions compel attention. More specific functions to be tested are writing and reading, special attention being paid to an inability to do these or to an unusually slow performance. (A simple 9-word sentence* should not take over 15–20 seconds to write, nor should the reading of a simple paragraph of 50 words exceed 35 seconds.)† Further simple tests of function[2] are: to carry out in proper logical sequence 3–4 tasks given simultaneously; to enumerate 28 objects with ease in a minute; to draw a man[3] or to copy simple forms.[4] In drawing, not awkwardness but rather purposeless lines revealing a lack of awareness of the essentials of the object to be represented are the criteria for feeble-mindedness.

(3) *Mental Tests.* Further investigation may be necessary to differentiate between the feeble-minded and the normal, when the above examinations arouse suspicion:

(a) *Arithmetic.* The moron is usually able to do the four basic operations, but will fail to recognize the one the problem at hand calls for. Thus practical problems involving purchases, the making of change, etc. should be given, rather than abstract ones. A simple addition and a simple subtraction task should be answered in less than 15 seconds

* "I am going to be a soldier very soon."

† "New York, September 5th. A fire last night burned several houses near the center of the city. It took some time to put it out. The loss was fifty thousand dollars, and seventeen families lost their homes. In saving a girl who was asleep in bed a fireman was burned on the hands."

each. A simple division and a combined multiplication and subtraction task should take less than 30 seconds each.*

(b) *Information.* The information of the feeble-minded person is limited. To avoid an arbitrary selection of questions testing information, it is advisable that standardized questions be used. Subjects failing more than four out of twelve standard questions are suspicious.†

(c) *Concepts.* The moron has difficulty in generalizing from particulars; this concept-formation can be most easily tested by asking subjects in what way two things are similar. Here again, certain standardized questions are most useful.‡ Three failures on standard questions should be regarded with suspicion.

(d) *Picture Completion.* Because of weakness in concentration and

* How many are four dollars and five dollars?

If you buy six cents worth of stamps and give the clerk ten cents, how much change will you receive?

If you buy eight cents worth of stamps and give the clerk twenty-five cents, how much change will you receive?

(The above questions should be answered in less than fifteen seconds.)

If one orange costs four cents how many oranges can you buy for thirty-six cents?

If you buy seven two-cent stamps and give the clerk a half dollar how much change will you receive?

(The above questions should be answered in less than thirty seconds.)

This selection of tasks was made on the basis of the test results of the writer and the statistics published in "A Study of the Sub-Tests of the Bellevue Intelligence Scale in Borderline and Mental Defective Cases," by David Wechsler, Hyman Israel, and Benjamin Balinsky[6].

† Who is the President of the United States?
Who was the President before him?
How many pints make a quart?
What is a thermometer?
How many weeks are there in a year?
When is Washington's birthday?
What is the average height of American women?
Who invented the airplane?
Where is Brazil?
What does the heart do?
What is the population of the United States? (After Wechsler[5].)

‡

Orange	Banana	Daily paper	Radio
Coat	Dress	Eye	Ear
Dog	Lion	Fly	Tree (After Wechsler[5], p. 153.)
Wagon	Bicycle		

survey of a situation, the feeble-minded individual has difficulty in discovering a missing part of a picture. Standard sets of such incomplete pictures are available.* Fifteen seconds are allowed for each picture; failure in more than seven out of fifteen standard pictures is pathognomonic.

One test administered by a person inexperienced in psychological testing will be insufficient to establish a diagnosis of mental deficiency. A failure in the majority of these four and in the writing, reading and drawing tests makes the diagnosis probable, and conspicuous failure in any one will be sufficient reason to give a detailed psychological examination.

Accordingly, the detection of mentally deficient registrants requires that: (1) Registrants whose education and professional standing are sufficiently high will be excluded from suspicion. (2) Physical signs of degeneracy especially of skull, eye, nose, and palate will be taken to indicate the necessity of careful examination. (3) After obvious cases have been eliminated, suspected cases selected on the basis of apparent clumsiness, lack of bodily equilibrium, blank stupid facial expression, reading-writing difficulties, and obvious peculiarities of drawing will be given special examination by means of the simple psychological test questions for which the norms have been given above. (4) Borderline cases will be further tested by a clinical psychologist.

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* Test materials of *Bellevue-Wechsler Adult Intelligence Scale*, "Picture Completion," Psychological Corp., 1939.

RECOGNIZING AND RENAMING "PSYCHOPATHIC PERSONALITIES"

By Karl A. Menninger, M.D.

HISTORICAL

Pinel described a "mania without delusions" which subsequent writers have regarded as being equivalent to what has in more recent times been designated "psychopathic personality."[1] It was mentioned earlier (1775) by Ettmüller, but Pinel's description is better. In 1837 Prichard[1] introduced the term "moral insanity" which dominated clinical discussions of this condition for the next sixty years. There were more arguments as to whether there could be such a thing as "moral insanity" than there were accurate descriptions of the clinical picture.

Early in the twentieth century Kraepelin,[3] Bleuler,[4] Adolf Meyer,[5] and Kurt Schneider[6] described the condition according to various classifications. The most important element in all of these was the elimination of the concept and implications of "moral insanity" and the introduction of more accurate delimitations of the symptom complex. There was a great lack of uniformity and unanimity in these descriptions. Meyer wisely excluded the neurotic syndromes which had been included by others but twenty-five years later (1931) Kahn[7] reintroduced them as forms of "psychopathic personality."

All of the earlier authors assumed the etiology to be primarily constitutional. Psychoanalytic and psychodynamic concepts, emphasizing psychological factors in the etiology, were introduced by Reich[8] ("instinct ridden character"), Alexander[9] ("neurotic character"), Karpman[10] ("anti-social character"), Wittels[11] ("phallic character"), and the present writer[12] ("perverse personality"). (See also Bartemeier[20] and Levine[21].)

For more details in regard to the history, the reader is referred to excellent summaries by Partridge[13] and by Sydney Maughs.[14]

CLASSIFICATIONS

In order to give some idea of the vagueness and polymorphous nature of the concept, the following classifications are worth a glance:

Kraepelin[3]

Excitable
Unstable
Impulsive
Eccentric
Liars and swindlers
Anti-social
Quarrelsome

Schneider[6]

Hyperthymic
Depressive
Insecure
Fanatic
Self-seeking
Emotionally unstable
Explosive
Affectless
Weak-willed
Asthenic

Partridge[13]

1. Inadequate
   a. insecure
   b. depressive
   c. weak-willed
   d. asthenic
2. Egocentric
   a. contentious
   b. paranoid
   c. explosive
   d. excitable
   e. aggressive
3. Criminal
   a. liars
   b. swindlers
   c. vagabonds
   d. sexual perverts

Kahn[7]

Nervous
Anxious
Sensitive
Compulsive
Excitable
Hyperthymic
Depressive
Moody
Affectively cold
Weak-willed
Impulsive
Sexually perverse
Hysterical
Fantastic
Cranks
Eccentric

The U. S. A. Surgeon-General[15]

Inadequate
Paranoid
Emotionally unstable
Criminalistic
Pathological liars
Nomads

World War[16]

Inadequate
Egocentric
Emotionally unstable
Sexual

British[17] (One of the most practical)

1. Contentious: (grievances, threats, abusiveness)
2. Mendacious: (lie or steal without apparent forethought)
3. Sexual: (uncontrolled, often perverse)
4. Skulking: (malingerers, work evaders, tramps, beggars)

SYMPTOMATOLOGY

Under an ambiguous title an excellent book has appeared recently by Cleckley[18] in which a list of essential symptoms is given which, modified somewhat by myself, is as follows:

1. Superficial attractiveness, cleverness, facility in talking, and often (not always) apparent intelligence.
2. Freedom from classical psychotic symptoms.
3. Complete unreliability and irresponsibility.
4. Total disregard for the truth, honesty, fairness and justice.
5. Continual projection of blame.
6. Absence of a sincere sense of shame.
7. Cruelty, cheating, bullying, etc., often apparent in childhood.
8. Impulsive, unwise, unpredictable generosity.
9. Bad judgment and inability to profit by experience.
10. Tremendous egocentricity with practically no capacity for object love.
11. General poverty of affect, including little if any sense of humor.
12. Little or perverse responsiveness to special consideration or kindness.
13. Very frequent prominence of excessive drinking, associated with shocking and fantastic behavior with little or no alcohol.
14. Utterly bizarre and preposterous conduct when drinking heavily.
15. Infrequent sincere suicidal attempts.
16. Striking peculiarities of sexual behavior—ostentatiousness, sordid surroundings, degraded and perverse objects, no restraint or taste, excesses, often impotence or frigidity or defeat of aim by drunkenness, aggressiveness, etc.
17. "Bad" companions elected consistently.
18. Playing off of one "friend" against the other, "double crossing" both.

(Cleckley includes, "Greater lack of insight than of any other psychiatric disorder." In my experience some have very keen insight; some have insight but cover it up; others have no insight.)

DETECTION

Diagnosis is usually based on the history of self-destructive perverseness along the lines indicated by the above symptoms, without organic brain disease, classical signs of psychosis, psychological tests indicating feeble-minded or outstanding neurotic syndrome. Hence detection must be based chiefly upon the one source of data not available to medical examining boards, the history. Detection in the course of examination may occasionally be possible from observing the regis-

trant's reaction to the total situation (challenging, indifference, smugness, evasion, lying, etc.) and his reaction to examinations (arrogance, malingering, impudence, disobedience, truculency, excitement, terror). Since deception is one of the essential features of the syndrome, these are the most difficult cases to detect, and the more difficult any particular case is to detect, the more important it is to detect it.

SPECIAL MORALE PROBLEMS INVOLVED

In the army these cases disturb morale in many ways: when dismissed and returned to civilian life, they continue to disturb morale, and most European countries tend to detain them under military control because of the latter fact. Military experience with psychopaths has been very bad for several reasons: (1) they give a false impression of superficial brilliance, and are later very disappointing; (2) they are essentially disloyal, if not actively mutinous; (3) they are a constant source of annoyance and trouble to officers, trying to evade assignments, provoking anger, stirring up trouble, etc.; their equipment is never in good order, they get into a lot of difficulty—petty thefts, etc.,—they are easy tools of propagandists. A few military psychiatrists feel that if they are predominantly cheerful some types may be useful in war under skillful leadership as shock troops and raid troops.

Psychopaths are so provocative that they excite revenge attitudes on the part of draft boards, officers, other soldiers, and the public generally with the result that there is a tendency to mistreat them, and thus give them occasion to justify their aggressiveness. There is a tendency against rejecting or dismissing certain of them from the army for the same reason, yet it is generally agreed that they are a heavy liability. (See excellent articles by Dunn[19] and Hall[2].)

A NEW NAME AND A NEW DEFINITION

What is now called "psychopathic personality," as I indicated above, has been called by at least a score of other titles, none of which is satisfactory, some because they are moralistic, some because they are meaningless, some because they imply dubious etiological factors, etc. I regard the term "psychopathic personality" as particularly bad since, logically, the schizoid or cycloid personality is also a "psychopathic" personality.

Alexander and some of the psychoanalysts tried to get away from

the term by using "neurotic character" and this practice we formerly followed at this Clinic. I do not approve of it now for three reasons: (1) It introduces the term "character" as something vaguely differentiated from personality; (2) The condition is closer to a psychosis than to a neurosis and the term neurotic is, therefore, misleading; (3) Alexander's emphasis was upon the unconscious sense of guilt and the resulting self-punishment which I do not think is the most important element in the condition.

What uniquely characterizes the syndrome we are describing? If one looks over the classifications and the symptoms, one gets certain very definite impressions, namely: (1) the patient of this type puts up a front or facade for the benefit of the person he desires to impress or exploit; usually he is hyperagreeable, sometimes the reverse; (2) he irritates, disappoints and distresses the doctor (and everyone else); (3) he does this by dissembling, lying, play-acting, pretending, etc. to cover up all sorts of aggressive self-exploiting behavior—in short, fraudulency and insincerity; (4) he breaks the rules as if he had a presumed impunity from the consequences which affect other people; (5) he maintains no consistent fealty.

All this can be interpreted to mean that these individuals are nearly overwhelmed by their hate and aggressive impulses and control them only by a continuous pretense which fools even themselves. They seem to live only for the moment, and that moment is filled with a grand show of intention contrary to the patient's deeper intentions. Hence they seem incapable of any sustained loyalties to anyone. Their need for signs of approval to prove that their aggressiveness remains unrecognized or unresponded to is so great that they dare to take chances and run risks that the normal person would not. They feel that they have everything to gain and nothing to lose, ***right now***; the future is a vague uncertainty.

In coining a new word to describe this personality type, it is important that we eliminate words having confused historical meanings, like "psychopathic personality," and words arising from the physician's sense of disapproval, resentment and annoyance, etc., such as "moral imbecile," "fraudulent personality," "insincere personality," etc. The following have occurred to me:

1. *Predatory personality* (describes without emotion or moralizing the

essentially aggressive, interpersonal relationships which these patients regularly establish with all other people).

2. *Sycophantic personality* (this refers to the attaching of oneself to a person and getting passive satisfactions paid for by flattery. It is essentially the same as parasitic and it may be somewhat moralistic).

3. *Histrionic personality* (this implies that the patient is acting out something never genuine, never himself, only pretending to be somebody whom he thinks the other person wants him to be).

4. *Facade personality* (because they put up a better front than even most normal people).

5. *Transilient personality* (the adjective is described in Webster as, "passing as by a leap from one thing to another; marked by breaches of continuity or abrupt transitions or variations"). It seems to me the most accurately descriptive.

The author believes that a new classification of personality types is needed, based on our new concepts of personality structure. But this classification and the place of the transilient personality in it will be dealt with in a subsequent article.

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MALINGERING

By Merton M. Gill, M.D.

Malingering may be briefly defined as fraud relating to matters of health. In connection with the Selective Service Act, one may speak of two broad classes of malingerers—the far larger group which is attempting to *evade* military service and the smaller group which is attempting to *enter* the service by disguising or denying some disability. It might be argued that it is not a matter of great importance to detect a malingerer since, if he is successful in his simulation, the Army is better off without him anyway. On the other hand, some men who have divided feelings about joining the Army might make good and loyal soldiers if their fraud is discovered and its reasons fully discussed with them.

The malingering selectee is rarely the resourceful juggler read about in books. The great majority of malingerers are simple, credulous, impressionable boys who exaggerate and invent without skill or without any specific plan. With the exception of cases in which deafness or blindness of one side is claimed, the only instruments required for detection of malingerers are those regularly employed in medical diagnosis. The individual who deliberately, skillfully and painstakingly concocts a simulation probably would be rejected for service anyhow, were he discovered.

Malingering can be divided into three degrees: pure malingering, partial malingering or exaggeration, and false imputation. In pure malingering the individual claims a disability without any organic basis or attempt actually to produce an organic disease. In partial malingering or exaggeration there is an organic substratum but the complaint would not warrant rejection and the malingerer therefore exaggerates it. False imputation refers to the fraudulent claim of an association between certain symptoms and an accident. This type of malingering is more prominent in civil life but can become very important in military psychiatry.

One of the most important problems in malingering is its differentiation from hysteria. The theoretical difference can be relatively simply stated: The malingerer voluntarily perpetrates a fraud for

conscious reasons; the hysteric involuntarily perpetrates a fraud for unconscious reasons. This difference is reflected in the subject's demeanor. The hysteric is dramatic, effusive and apparently naive. The malingerer is inclined to be defensive, surly, evasive and suspicious. The two groups differ widely in their reaction to inconsistencies pointed out in their complaints or behavior. The hysteric seems more or less unperturbed. The malingerer, however, is immediately on the defensive and becomes disturbed if an inconsistency is discovered. The hysteric is chiefly concerned with his symptoms. To him the question of acceptance or rejection is relatively subordinate. The malingerer, on the other hand, is especially concerned with the problem of rejection. The hysteric cannot be examined too much; he revels in it. The malingerer is reluctant to be examined and does his best to cut short the examination.

The most important basis for detecting the malingerer and, unfortunately, the one which in the present setup seems to be least available, is the history. The malingerer may claim, for example, that he never advanced beyond the third grade and simulate stupidity but a reliable history will at once brand him a liar. In most disqualifications for neuropsychiatric disabilities the examiner must be on the alert to find something amiss. The malingerer, however, calls his disability to the examiner's attention.

The first general examinational method for uncovering the malingering registrant is by misleading him. For example, in an individual who claims that he is deaf in the left ear, if the examiner places his finger in the selectee's right ear and holds the vibrating tuning fork behind the left ear and asks him if he hears it, he may very well say that he does not and thus be exposed in his fraud. A second general method is the distraction of attention. A classical example is to whisper suddenly to a man who claims deafness that his trousers are unbuttoned. The production of bewilderment is a third method. For example, a registrant who claims a visual disability may be presented with cards on which are letters of varying sizes at varying distances. The individual will be unable to fake a consistent degree of disability. A fourth method takes advantage of the inherent deficiency of human capacities for observation and the malingerer's difficulty in reproducing phenomena. This method is particularly useful in a case of simulated sensory disturbance. In some instances where the suspicion of simu-

lation is strong but no proof can be obtained, it may be necessary to place the individual under a period of constant observation to catch him "with his guard down."

In the complaint of spontaneous pain one should note the presence or absence of facial alterations, focal morbid changes and accessory motor, vasomotor and secretory phenomena. In simulated sensory disturbances it should be remembered that in genuine cases a sensory defect is usually only one feature of the general syndrome. This the malingerer overlooks, and furthermore he is unable to simulate the whole clinical picture. Pain in the back is fairly frequently simulated because of the difficulty of establishing or refuting the truth of such a complaint. In such instances one should carefully observe the pose, gait and general conduct. The same is true of limp and pain in the leg. In simulated Rombergism the malingerer overacts his part. In simulated vertigo the malingerer will suppress his instinctive efforts to retain his balance when in danger of a fall. The voluntary production and maintenance of a tremor involves exertion and sooner or later the signs of fatigue appear. A simulated contracture shows an irregularity of movements and respiration which is absent in the hysterical form. To detect a simulated paralysis one should vary the direction of the pull of gravity, distract the attention from the paralyzed part, and interrupt rapidly executed passive movements. Simulated disabilities in vision or hearing can usually be easily detected by misleading the registrant either by causing him to overact his part, by actually testing him in behavior which is preliminary to what he considers the real testing situation, and by using technical devices in which he thinks he is using either the right or the left organ when it is actually the other one which is being tested.

Various drugs can be taken to change the character of the excretions or to alter the clinical signs of the viscera such as the cardiac action, for example. Inconsistencies and incomplete syndromes should furnish the clues.

The attitude of the physician toward the malingerer assumes a peculiar prominence. The malingerer is attempting "to put something over on the doctor." When the examiner detects the malingerer he is likely to respond to this aggression by hostility of his own and to make his decision concerning the suitability of the applicant for military service not on the basis of the scientific evaluation of the data

but on the basis of his personal feelings of hostility and desire for revenge. Furthermore, the malingerer is looked upon as an individual who is attempting to shirk his civic responsibilities. The physician may see himself as the personification of the conscience of the State and make his decision in terms of punishment. A physician who has unconscious hostility against the Army because he, himself, was drafted may base his decision on his desire to see that others be forced to serve the State too. A physician opposed to the draft may identify himself with the malingerer and declare him unfit, rationalizing that he would not have made a good soldier anyhow. The essential point to bear in mind is that it is the physician's function on the basis of scientific and medical considerations to make his decision in the individual case on the basis of whether the induction of the person in question would hinder or assist the efficient development of the defense program on which the country has embarked. Factors which should rule against the induction of a malingerer are: a record indicating that the pattern of malingering is deep-rooted, painstaking and elaborate simulation, evidence that the recruit is "poor material" in any case, and the absence of a "reasonable" and condonable motive for attempting to evade service.

RECOGNIZING THE PSYCHONEUROTIC REGISTRANT*

By Robert P. Knight, M.D.

For purposes of registrant classification, the psychoneuroses include the non-psychotic, functional psychiatric disorders, and may be divided into three main groups: (1) The classical psychoneuroses; (2) The psychosomatic conditions or organ neuroses; and (3) The immature or poorly adjusted character types. I shall attempt to present such a threefold classification of the psychoneuroses, with brief descriptive data for each individual category.

THE PSYCHONEUROSES†

1. *Neurasthenia*—characterized by lack of energy, easy mental and physical fatigability, feelings of pressure or tightness in head and neck, on the spine, various gastro-intestinal complaints, often low blood pressure, and generally reduced vigor without initiative or capacity for exertion.

2. *Anxiety Neurosis and Anxiety Hysteria*—characterized by intense fear with vague content, feeling of impending death, dread of serious disease or insanity or other phobias, with associated palpitation, giddiness, dyspnoea, trembling, faintness, vasomotor disturbances, nausea, diarrhoea, pavor nocturnus. (If main accent is on cardiac complaints, probably identical with effort syndrome, to be mentioned later.)

3. *Hypochondria*—intense preoccupation with bodily organs, with delusions of organ disease. Conviction of disease without supporting physical and laboratory findings. All normal bodily sensations noticed, magnified and interpreted as evidence of serious disease.

4. *Hysteria*—Psychogenic paralyses, blindness, seizures, amnesias, fugues, contractures, anesthesias.

5. *Compulsion or Obsessional Neurosis*—(sometimes called "Psychasthenia"). Intense indecision, counting and touching compulsions, elaborate rituals of long standing, or obsessional fears of going crazy,

* Condensed from a paper read at the Chicago Seminar on Practical Psychiatric Diagnosis for Selective Service Registrants, May 19, 1941.

† The older and more familiar terminology is used in place of more recent and more accurate designations.

of doing something terrible such as killing a loved one, or of doing something repulsive and embarrassing.

PSYCHOSOMATIC CONDITIONS

We have long been aware that individuals with psychoneuroses may develop psychogenic physical symptoms, and especially through the research work of the past decade we have seen more clearly that certain conditions before regarded as organic illnesses may develop from emotional origin. I shall not attempt to present an exhaustive list of the so-called psychosomatic conditions (also called organ neuroses, functional disorders, and psychogenic physical diseases) but shall list only the outstanding conditions in regard to which the Selective Service examiner must be alert.

1. *Effort Syndrome* (D. A. H., Soldier's heart, Irritable heart, Neurocirculatory asthenia). The term "effort syndrome" is now preferred for this condition and is in common use in British military psychiatry. In the First World War it was not recognized as a psychiatric problem, and thousands of cases were invalided home with cardiac diagnoses—an unfortunate state of affairs both for the patient who became convinced of the organic nature of his illness and thus became impervious to the delayed attempts at psychiatric treatment, and for the government which had to make large expenditures for hospital and medical care and compensation. All of the symptoms of this condition are exaggerated somatic responses to anxiety, with the accent on the cardiac complaints. Dyspnoea, dizziness, palpitation, pain in the chest, fatigue, diarrhoea occasionally—all are apparent cardiac symptoms, without the supporting physical and electrocardiographic findings for a diagnosis of organic heart disease.

2. *Peptic ulcer*—Large numbers of soldiers have already been invalided home to Canada and Britain in the present war suffering from peptic ulcer, although the original physical examination did not disclose any such lesion. Asymptomatic ulcer may escape the examining physician, or the predisposition to ulcer, sometimes called "ulcer personality" may be even more difficult to detect. The ulcer personality is characterized by tenseness, hard driving, compulsive achievement with denial of and suppression of passive wishes. There is a greatly over-emphasized independence, frequently as an over-compensation against the repressed passive wishes. Such individuals achieve much

and are valuable until the ulcer syndrome overtakes them. It is doubtful if the short time allowed for psychiatric examination will permit recognition of many of these candidates for peptic ulcer, but keeping the prospect in mind may enable the examiner to identify the more obvious cases.

3. *Hypertension*—So-called labile, or functional, or emotional hypertension in which the individual reacts to repressed rage by markedly elevated blood pressure is a condition which may lead later to a structuralized or fixed hypertension, and thus render the registrant unfit for military service. The cold pressor test, giving a positive reaction for such cases, is a valuable adjunct in recognizing this condition.

4. *Hyperthyroidism*—may have an important factor of constant deep anxiety in its etiology. Thus, those individuals with a hyperthyroid diathesis or sub-clinical hyperthyrodism may blossom forth under military stress, and probably should not be accepted for combat duty.

5. *Functional gastro-intestinal conditions*—such as mucous colitis with diarrhoea attacks in relation to frustration or other emotional upset, the gas neuroses with a history of bloating, distress, dyspepsia and so on in relation to emotional instability may develop more serious degrees of these conditions in the army, or may even develop fixed or structuralized organic diseases from this psychogenic beginning.

6. *Some other psychosomatic conditions* are recognized which will probably not often be seen by the psychiatrists. These include bronchial asthma, certain skin conditions, some cases of diabetes, and other conditions of lesser importance.

PERSONALITY OR CHARACTER DISORDERS

We come now to the most diverse field to be included under the broad category of psychoneuroses, the personality or character disorders. One of the most important factors in a developing psychiatric condition is *predisposition*. The other two, as is well known, are constitution and precipitating or traumatic factor. The predisposition is already built into the personality structure, and it has become one of the diagnostic problems of psychiatrists in civil practice to diagnose and treat these personality disorders. In examining registrants this sort of recognition of predisposition, or pre-morbid personality type becomes of paramount importance. It is in this very field, however,

that we, in our present state of psychiatric knowledge, are less able to diagnose and classify definitive types and predict the probable morbid conditions which will develop. On the basis of the available knowledge, I shall try to present a list of character types which should be rejected.

1. *Anxiety personalities* (for want of a better term) are those timid, frightened, ineffectual individuals who react easily to the mildest stress or crisis or expectation of demand on them with anxiety and disorganization of logical thinking and effective motor responses. Such personalities are easily detected, and are often called "constitutional psychopathic inferiors." The army will not make men of these individuals, and while they may find a niche in civilian production, they have no place in the armed forces.

2. *Dependent, infantile or parasitic personalities*—These individuals present a better front than the anxiety characters, but are extremely immature emotionally, can be found to be strongly attached in a dependent, clinging fashion to one or more strong figures—parent, sibling, business partner, wife—and to be sometimes helpless and ineffectual alone, and sometimes petulant and demanding of help, protection and verbal reassurance. They have the permanent "on relief" attitude and expect always to be taken care of by a strong individual or agency. This is sometimes known in this country as the "W. P. A. attitude," and social case workers are very familiar with this type. They may even try to enlist, as many are reported doing now in Canada, in order to get "on the government" for life by sustaining an injury or breaking down in the armed forces. In order to get by the medical and psychiatric examiners they may put up a good front, and it is in these cases that social case records, relief records, and work records are most useful and important.

3. *Schizoid, isolated or lonely personalities.* (Described in detail in Dr. Tillman's paper.)

4. *Paranoid personalities*—characterized by a suspicious, close-watching attitude, inclination to project blame onto others, talk of perpetual bad breaks, of discriminations against them by others, and of enemies. They are likely to watch closely the examiner's every move, especially his recording of data, and may ask questions indicating paranoid suspiciousness. Contrary to the popular conception that persons with aggressions so near the surface should do well in war, they are much more likely to stir up dissension in the ranks, develop delusions of

persecution against commanding officers, and cause all kinds of trouble. Acute paranoid explosions, with homicidal bursts of aggression may occur.

5. *Candidates for traumatic neuroses**—In a lucid and helpful article, Kardiner reviewed his experience with several hundred cases of traumatic neurosis (shell shock, war neurosis) after the First World War. He believes that individuals with the following signs are likely candidates:

a. Stammering—these persons have already reacted to some childhood emotional shock by a convulsive symptom involving the organs of speech.

b. Tics—also an indication of a pattern of developing a convulsive defensive, magical movement, usually of the facial muscles, sometimes of the arms or shoulders, against some kind of shock.

c. History of convulsive phenomena, easy fainting, or inability to stand the sight of blood.

According to Kardiner, all of these signs are almost pathognomonic of a personality type which has no name but which marks the person as a likely candidate to react to the shocks and terrifying experiences of war with a traumatic neurosis.

6. *Addiction personalities*—The dependent, demanding, parasitic personalities described above, often have alcoholism or drug addiction. Also there are some individuals of other personality types in whom excessive drinking seems to be an essential element associated with all their activities. Again, military life will rarely cure an addiction to alcohol or drugs, and a history of such addiction should be a basis for rejection of a registrant.

7. *Overt sexual perversions*—especially homosexuality, exhibitionism or fetishism. Such cases should probably be rejected on the likelihood that their activities will bring about social ostracism, being "picked on" and other complications in the armed forces. Some otherwise well adjusted cases of perversion may become useful members of the army.

8. *Cyclothymic or moody personalities*—Unless the registrant is obviously depressed or excited, detection of this disorder can be made only on the basis of a history of cyclic episodes.

9. *Psychopaths*—(Discussed in detail in Dr. Karl Menninger's paper.)

10. *Malingerers*—(Discussed in detail in Dr. Gill's paper.)

* Kardiner: The Neuroses of War; *War Medicine*; 1:219–226, March 1941.

CONCLUSION

The psychiatrist who examines registrants must be constantly aware of the types of stress to be encountered by an accepted selectee, of the principles of repetition of patterns of reaction in military life that the history of the registrant showed to be operative in civilian life, and must possess subtle diagnostic skill in order to detect pre-morbid types. The value of records of school, occupation, courts, mental hospitals and relief agencies has been stressed, and it has been suggested that social workers, lay draft boards or other lay workers could perform a great service by compiling, condensing and supplying these records to medical and psychiatric examiners. Three major divisions of non-psychotic, functional cases—well developed psychoneuroses, psychosomatic conditions, and personality disorders—with the individual sub-categories under each have been presented as conditions which should be watched for and rejected.

DETECTING SCHIZOID AND PRE-SCHIZOPHRENIC PERSONALITIES

By Carl-Gustaf D. Tillman, M.D.

The Examining Board physician for whom this paper is primarily intended is in a particularly important position in regard to the registrant with a schizoid personality. If he detects and excludes the schizoid registrant, he performs an act of humanitarian value and also directly contributes towards the maintenance of an efficient fighting machine because the schizoid personalities are especially vulnerable to a breakdown if inducted into the armed forces.

Men of draft age who fall into the schizoid group superficially may present many individual differences, yet underneath they all have certain common characteristics. The schizoid and pre-schizophrenic personality does not present the features of a well-developed active psychiatric syndrome but instead shows a long time maladjustment in the sphere of his interpersonal relationships which is often of a subtle, inconspicuous nature. Already in school the schizoid person is apt to take the daily exchange of give and take in a much more serious and acutely personal way than do his playmates. The joke or "crack" directed at him is not avenged, laughed at and then forgotten but instead is brooded over and applied personally to himself long after his playmates have forgotten it. The "snub" by the teacher or reprimand by a superior lingers in his mind often as a bitter seed far out of proportion to its original intent. The schizoid personality early reacts with insecurity, fear, self-criticism, and unexpressed resentment towards situations which for the average person are simply part of everyday experience and interpersonal contact. It is as a defense reaction to these feelings that the schizoid person sometimes develops the manners, habits, tastes and interests which mark him as queer and different. By developing hobbies and interests which he can pursue by himself and which are not generally shared by others, he has an opportunity to seclude himself from those contacts which to him are so painful. Unusual interests in which the average person may not be able to participate give the schizoid person seclusion and isolation from human contacts and enable him to gain self-satisfaction and overcome feelings of inferiority.

Because of his deliberateness of purpose and intensity of effort the schizoid often becomes a valuable member of the community. As long as he is in a position where he can isolate himself from the demands and threats of human contact for greater or shorter periods (but always longer than that which the ordinary person requires) he may continue to function in an efficient way, sometimes throughout his life. Being well aware of his own difficulties and often quite intelligent, he gradually works out a pattern for himself which he can maintain indefinitely and in which he may make important contributions to the community. He is not so much maladjusted as he is lacking in adjustability. In civil life with its numerous opportunities for queer and unusual people to get along, the schizoid person may do very well in his own particular way despite his lack of flexibility. In military life with its demand for uniform behavior, its intolerance of the queer, and the constant and intimate association with other people for twenty-four hours of the day, the schizoid person meets the very situation which all of his life he has tried to avoid and which he cannot master or endure; hence the schizophrenic break-down which so often appears after induction in selectees of this type.

DETECTION

The schizoid personality could be easily detected by the draft board physician if a careful life history were taken. However, there is no time for this. The examiner must instead concentrate on the registrant himself and from him obtain clues which should lead to the psychiatrist on the medical advisory board being consulted. Several aspects of this examination will be briefly described.

The registrant's attitude may be one of disinterest or extreme calmness, both representing attempts on his part to cover his inner insecurity; or he may be overly friendly, making unnecessary approaches to the examiner and inquiring about his health in a manner quite out of keeping with the situation. Many schizoid men will be embarrassed, tense and nervous, and often in some subtle way create a distinct feeling of unpleasantness within the examiner himself. If asked how he feels about the examinational procedure and the prospect of joining the Army, the average healthy person will admit a certain amount of nervousness and concern, whereas the schizoid person will either vehemently deny such feelings or will soon make clear to the examiner his extreme anxiety and apprehension, both types of responses

being highly significant. Questions about his body may bring out unfounded convictions of bodily peculiarities which are especially significant if they are attributed to excessive sexual acts.

Various dissociated phenomena may be expected of the undressed registrant as he passes through the examinational procedure. From the schizoid person these tend to be especially noticeable and frequent. General muscular tension as well as localized fibrillations are often observed, especially around the mouth and eyelids. Signs of anxiety such as perspiration, tachycardia, borborygmus, etc. are more frequent and of greater amplitude in the schizoid than in the healthy personality. Shielding and covering of the genitalia may be seen, and calling this to the registrant's attention may cause him considerable confusion. Any dissociated phenomenon should be called to the registrant's attention, and his explanation of it gives the important clue. It isn't the phenomenon itself as much as what the registrant has to say about it which is important, and in the case of the schizoid person the examiner will be struck by peculiar, irrational, incongruous answers. A few questions must always be asked directed at the registrant's interpersonal relationships, sexual life and vocational history, as much significant material can be obtained. He may divulge that he has always thought of himself as having persistent tough luck or delicate health, or that he has quit several jobs because his associates bothered him in minor and subtle ways which to the average person would not be important.

Perhaps the most important as well as the most difficult point to describe is the examiner's own reaction to the registrant. If the examiner feels bored or obscurely annoyed by the registrant and if he is struck by vagueness, uncertainty and evasive tendencies the examiner should be especially on his guard and should objectively ascertain his subjective response to the registrant because quite likely he is dealing with a schizoid personality. If he finds, even after several gentle but leading questions, that the registrant's attempts to make things clear only create additional confusion, he may be almost certain that the case should be referred to the advisory board psychiatrist. Examining scores of young men daily, the examiner soon acquires a feeling about them. Any registrant who in any way arouses different feelings, whether these be of dislike, puzzlement, vagueness or indecision, is a proper subject for more careful investigation.

A type of registrant related to this schizoid group and often a mem-

ber of it is the physically normal yet effeminate and "sissy" individual. This effeminancy is much less outspoken than that often observed in overt homosexuals; yet by gestures, gait and voice the examiner's attention may be engaged. Many of these men belong to the schizoid group and all are unfit material for military life as they soon become subject to ridicule and "joshing" which will harm the general morale and will incapacitate the individuals for Army duty.

In conclusion, a few words should be said concerning the examiner's technique in trying to evaluate the degree of schizoid personality a registrant possesses. If the examiner preserves a neutral, non-critical attitude and avoids being either severe or overly friendly, the schizoid person will react in his own characteristic ways. If the examiner refrains from pressing the registrant for further answers when he has already made statements which have aroused the examiner's suspicion, the schizoid registrant may often further give himself away, thus confirming the examiner's suspicion.

DETECTION OF THE MORE COMMON NEUROLOGICAL CONDITIONS

By Harlan Crank, M.D., and Lewis L. Robbins, M.D.

Inasmuch as grossly disabling neurological conditions are readily recognizable, the following outline is for the purpose of assisting physicians examining registrants in detecting early evidences of neurological disease. The essential procedures of a minimal but adequate neurological examination are listed and only the early manifestations of each neurological disorder are given.

A. *Suggested examinational procedure:*

1. *Minimal procedures with registrant standing:*
   a. Initial survey for gait, postural adaptations, attitudes.
   b. Quick survey of musculature for evidences of atrophy, asymmetry, abnormal tone, paralysis, abnormal involuntary movements (tremors, tics, fibrillations).

      (High arched foot, hammer toes suggest Friedreich's ataxia and allied disorders.)

   c. Inspect skin for cafe-au-lait spots, vascular nevi, post-anal dimple, injection or burn scars (may indicate sensory disorder).
   d. Have registrant walk straight line, watching automatic associated movements; then have him stop suddenly, turn around. Then repeat performance with eyes shut to bring out latent or mild ataxias.

      (Absence of associated movements in walking suggests Parkinsonism, cerebellar disease; scraping of feet in walking suggests that one look for signs of spasticity; wide base swaying in walking suggests tabes dorsalis, cerebellar disease, multiple sclerosis.)

   e. Observe Romberg's sign with arms extended, eyes closed, and with registrant counting aloud. Latent tremors and muscular incoordination brought out in this way.

      (Asymmetry of posture of outstretched hands suggests hemiparesis or peripheral nerve disease, alcoholic neuropathy; ataxia or tremor of arms or hands suggests paralysis agitans, multiple sclerosis, cerebellar tumor; positive Romberg signs suggest tabes dorsalis, multiple sclerosis.)

f. Have registrant place hands at back of head, bend from side to side at waist; then raise hands above head and bend forward, and attempt to touch toes. Back pain and structural limitations of motion are brought out in this way.

g. Observe and palpate skull for scars, depressions, protuberances. Also interrogate registrant regarding headaches and note manner of speech.

(Scars suggest epilepsy, old skull fractures; chronic severe headaches suggest expanding lesion, migraine; slurred speech suggests multiple sclerosis, degenerative brain disease, cerebellar tumor, paresis.)

2. *Minimal procedures with registrant sitting on table:*

a. Observe pupils; check extra-ocular movements and note nystagmus or strabismus; facial symmetry; have him show teeth (for facial weakness and peri-oral tremor) and protrude tongue. Observe fundi if indicated.

(Exophthalmos, enophthalmos suggest disorder of cervical cord, brachial plexus, or cervical sympathetic chain; inequality or irregularity of pupils, Argyll-Robertson pupil suggest syphilis of the central nervous system; nystagmus or strabismus suggest labyrinthitis, multiple sclerosis, cerebellar tumor; unilateral facial weakness, flaccidity or over-activity must be differentiated as to peripheral or central type. Look for evidence of other cranial nerve palsies, hemi-Parkinsonism, myasthenia gravis. Atrophy or fibrillation of tongue suggest progressive muscular atrophy, amyotrophic lateral sclerosis, syringomyelia.)

b. Observe finger to nose test for dysmetria and ataxia. Check sensory modalities as indicated.

c. Have registrant lie down and relax. Muscle tensions, suspicions, anxieties often arise here.

d. Quickly check biceps reflexes of upper extremities—if any reflex inequality, check both biceps and triceps; then abdominals; raise knees with arm allowing heels to drag and compare patellar jerks. Then check ankle jerks and Babinski. Watch for unusual inability to follow instructions, to relax; sensitivity to plantar stimulations; withdrawal simulating Babinski. If hyper-reflexia present, look for other signs of anxiety, etc. If hyporeflexia or areflexia, try reinforcement techniques.

(Inequality of deep reflexes suggests hemiparesis, polyneuritis; exaggeration of deep reflexes, ankle clonus suggest hemiplegia, paraplegia, multiple sclerosis, sub-acute combined degeneration, cord tumor; absent tendon reflexes in spite of reinforcement suggests tabes dorsalis, polyneuritis, Friedreich's ataxia; absent or unequal abdominal reflexes suggest multiple sclerosis, hemiparesis.)

B. *Manifestations which disqualify regardless of diagnosis:*

1. Convulsions, periodic severe headaches or fainting spells.
2. Psychotic episodes.
3. Severe tremors or other involuntary movements.
4. Palpably depressed or compound skull fractures.
5. Optic atrophy, retro-bulbar neuritis, choked disks.
6. Any cranial nerve paralysis.
7. Definite vertical nystagmus. Any nystagmus associated with strabismus.
8. Paralysis of upward gaze, ophthalmoplegia.
9. Monoparesis, hemiparesis, hemiplegia, paraplegia, muscle clonus, positive Babinski or Oppenheim's sign.
10. Muscular atrophy if not due to poliomyelitis or peripheral nerve lesions and if incapacitating.
11. Definite consistent "saddle" anesthesia.
12. Definite aphasia.

C. *Diagnostic criteria of commoner disqualifying neurological disorders:*

1. *Paroxysmal Disorders:* (The epilepsies, migraine, narcolepsy) No physical findings. History of spells of unconsciousness, convulsions, dizziness, fainting, or paroxysmal headaches.
2. *General Paresis:* Infrequent in registrant age group. Unequal and/or irregular, sluggish or Argyll-Robertson pupil or pupils; tremor of extended hand, face, and protruded tongue; speech defect in test phrases and conversation; writing defects; apathetic, depressed or euphoric moods; defective memory especially for recent events; acalculia. Progressive spastic weakness of legs with increased tendon reflexes, although knee jerks may be normal, hypoactive or hyperactive.
3. *Tabes Dorsalis:* Unequal, irregular or Argyll-Robertson pupil or pupils, diminished pupillary light response, absent knee jerks, diminished knee and absent ankle jerks; positive Romberg, ataxic arms or legs increased when eyes are closed; hypotonia; anesthesia of skin areas. History of slow progression with failing potency, sphincter disturbance, "rheumatic" pains in leg or back or abdomen.
4. *Meningo-vascular or Cerebrospinal Syphilis:* Headaches, history of mood changes or convulsions, varying deep and superficial reflexes, pupillary changes, ptosis, ocular palsy, facial paresis. Mental state normal, dull or apathetic. Motor weakness on one side or in one extremity.
5. *Parkinsonism:* History of encephalitis or influenza in about 50% of cases. Frozen facies, unwinking stare, rigidity of muscles, stooping posture, slow movements, tremors; slow, monotonous

speech. May be unilateral. Loss of automatic associated movements.

6. *Athetosis, Dystonia, Chronic Chorea, Spasmodic Torticollis:* Often associated with evidence of spastic paralysis. Simulation is possible.
7. *The Myopathies:* Familial history. Weakness of certain muscle groups with slowly progressive atrophy. Myotonia may be present, especially in grasp. Postural and gait disturbances.
8. *Post-traumatic Cerebral Syndrome:* History of head injury followed by headaches, dizziness, loss of initiative or personality change. Hypersensitivity to alcohol and heat. Slight nystagmus, fine tremors, vasomotor changes, abnormal sweating.
9. *Multiple Sclerosis:* History of transitory weakness, numbness, or ataxia of one or more extremities, or transient diplopia, scotomata or blindness. Optic atrophy, nystagmus, corneal hypesthesia, absent or irregular abdominal reflexes, exaggerated deep reflexes, positive Babinski or Hoffman sign, ataxia, euphoria.
10. *Syringomyelia:* Wasting of small muscles of hand; dissociated loss of sensibility to pain and temperature in patchy areas over arms and chest; slight spastic paraplegia with reflex changes; scoliosis. Cigarette burns on fingers and cold, sweaty, cyanotic hands are highly suggestive.
11. *Chronic Neuralgia:* History of severe or chronic recurrent pain confined to area of peripheral distribution of single nerve with few, if any, objective changes; may have areas of hyperesthesia or "trigger zones"; partial or complete remissions between attacks.
12. *Local Neuritis:* Pain or other sensory or motor changes along distribution of single nerve, especially in presence of adequate cause. Rarely disabling.
13. *Multiple Neuritis:* History of sudden or gradual onset of weakness of many muscles usually with pain or hyperesthesia and some sensory loss. Affected muscles flaccid and atrophied. Reflexes lost. Often history of poisoning by chemical agents or vitamin deficiencies. Recovery rarely complete.
14. *Brain Tumor:* History of cerebral disorder progressive over months or years. Convulsions, mental changes, paralysis, ataxias, and other focal manifestations.
15. *Heredo-degenerative Group:* (include wide variety like Friedreich's ataxias) Familial history. Incoordination of voluntary movements and gait. Slurred, ataxic speech, nystagmus, spastic

paraplegias, optic atrophy, mental impairment, and occasionally muscular rigidity and tremor.

16. *Sub-Acute Combined Degeneration:* History of numbness of fingers and toes with difficulty in walking. Spasticity of extremities, loss of vibratory perception, and atrophy of tongue.
17. *Amyotrophic Lateral Sclerosis:* Atrophy of muscles usually beginning in hand and later involving arm and shoulder girdle accompanied by weakness, fibrillations in affected muscles, and increased myotatic irritability.
18. *Tumor of Spinal Cord:* Combination of paraplegia with sensory level, segmental or root pain or atrophy. Pain increased by bending spine, coughing, or straining at stool.

PSYCHIATRIC PROBLEMS OF THE ARMED FORCES IN TRAINING AND IN COMBAT

By Robert P. Knight, M.D., and Douglass W. Orr, M.D.

Military psychiatry deals with minor problems of maladjustment as well as with acute psychoneurotic and psychotic conditions developing in troops. Some cases of psychopathology will slip unnoticed by the Selective Service examining boards only to become painfully apparent a few days or weeks after induction. Others will arise because of the peculiar conditions and viscissitudes of military life in training camps. Still others must be expected if the severe stresses of modern warfare are encountered. This presentation will be concerned with the nature of the problems to be expected and some suggestions for their treatment.

It is to be expected that many men with overt psychopathology will elude even the careful and unhurried psychiatric examiner. Especially will this be true in those conditions in which a man is able to "rise to the occasion" and put on a good front and in which diagnosis is normally based as much upon history as upon direct examination of the patient. This group will include some alcoholics and other addicts; many mild manic-depressive persons, especially in a latent or intermediate phase; overt but undetected homosexuals; and the whole group of psychopathic personalities who are noted for their charm and ease of manner when they want something. In addition, there will be some cases of hysteria—"who love excitement, and are at their best at the examination"—and of early schizophrenia with a good facade. Unless adequate life-history data are at the disposal of Selective Service examiners, they are not to be blamed if such personalities slip by them into the Army.

In considering the reactions of men to military life during the training period, it is well to recall that everyone develops increased anxiety in any new situation; with such an added increment of anxiety there come into play various normal and, perhaps, pathological defenses against this anxiety. Some personalities, no matter how apparently well-adjusted in civilian life, will be vulnerable to the special conditions of military training: monotony, discipline, segregation from the

opposite sex, constant association with other men, freedom from home ties, necessity to win prestige in a new group and in unfamiliar activities, and so on. Men whose previous adjustment has been precarious at best or whose personalities are especially threatened by the special conditions of military life may become psychiatric casualties even during the training period.

It is impossible to anticipate every type of disturbing influence in training or all types of reaction to be expected. The following is a tabulation, however, of commonly encountered personality types, the stresses likely to threaten their accustomed adjustment, and the pathological reactions that may ensue:

personality type	*source of stress*	*type of "break"*
1) Intellectually inferior personalities	Training too complex; butt of companions' practical jokes; inability to compete, etc.	Feelings of inadequacy; confusion; retreat into illness or protest reactions transgressing army discipline
2) Dependent personalities	Absence from home supports	Severe homesickness; frequent sick call for "flu"; desertion, etc.
3) Neurotic personalities	Any unpleasant or difficult situation; monotony, discipline, night duty, etc.	Frequent sick call; psychosomatic illnesses: "flu," peptic ulcer, marked fatiguability, etc.
4) Suppressed or "held down" personalities	Absence of supervision of personal life, as in time off and away from camp	Excessive drinking and sexual activities leading (?) to venereal disease or breaches of discipline
5) Inhibited or "sheltered" personalities	Association with more emancipated, sophisticated men	Anxiety; panic; acute psychoneurosis
6) Psychopathic personalities	Monotony, regularity, discipline	Rebellion, other protest reactions; A.W.O.L.; alcoholism, etc.
7) Men with strong unconscious homosexual conflicts and inadequate or precarious defenses	Constant, daily association with large groups of men; little association with women	Panics; acute alcoholism; schizophrenic reactions
8) Schizoid personalities	Enforced, constant association with others	Panic reactions; frank schizophrenia
9) Hysterical and hypomanic personalities	Routine, monotony; discipline	Stirring up excitement for its own sake; excessive zeal; poor judgment

personality type	*source of stress*	*type of "break"*
10) "Normal" men accustomed to active sublimated or direct heterosexual expression	Segregation from opposite sex; enforced relative or absolute continence; unwillingness of "nice girls" to have dates with army men; conflict between desires of men in camp and what public opinion thinks is good for them	Hostility toward army or nearby communities; conflicts over masturbation or "wet dreams"; anxiety about going to prostitutes; anxiety about homosexual temptations: all depending upon previous moral, social or religious attitudes

Treatment of these conditions must be both preventive and active. Preventive treatment will include public education as to the psychological needs of soldiers, more adequate recreational facilities in or near camps, and better arrangements for normal social intercourse between soldiers and girls. General officers in the armed forces need instruction in general psychiatric principles because upon them falls the burden of discipline and of expediting the discharge of neuropsychiatric casualties. Beyond this, paper plans for divisional or regimental psychiatrists require translation into reality. The care of psychiatric difficulties at present becomes the responsibility of army chaplains or is made a matter of military discipline.

Psychiatric problems arising during actual combat are usually much more readily recognizable as such and require active and early treatment by a psychiatrist. The stress during modern warfare involves endurance of permanent danger with controlled fear, terrific visual and auditory experiences, severe physical pain, tremendous frustration as to food, water, rest and sleep, participation in direct killing and destruction, and the necessity to maintain an attitude of self-sacrifice for an ideal. Without intensive army camp training and discipline not many individuals could withstand such stress; even with such training some men will break down and develop actual psychoses, war neuroses (formerly called "shell shock") or various psychoneurotic conditions which are not specific for war stress.

In World War I the war neuroses consisted of 70% anxiety states, 20% hysteria, and 10% mixed cases (stupors, confusional states, fugues, amnesias and combined types). It has been prophesied by British psychiatrists that this war will bring out fewer hysterias, more anxiety states and probably more psychosomatic disorders. There were several, now well-known, mistakes in psychiatric handling of

casualties in the first world war. The first was *delayed treatment*, sometimes unavoidable due to handicaps in transporting the men to field stations or base hospitals, or to insufficient number of doctors or psychiatrists, so that the physically wounded were cared for while the psychiatric casualties waited. A second error was *insufficient treatment*—mistaking disappearance of symptoms for recovery, and returning a man to action too soon, with the result that he developed a more serious type of disorder promptly. A third error consisted of treating many effort syndrome cases (D. A. H.) and other psychosomatic conditions as organic cases, mentioning organic diagnoses to the patient, with the result that many such psychogenic cases became "fixed," and untreatable by psychiatric methods. A fourth mistake was the discharging of many cases from service with compensation instead of undertaking treatment. (This "payment for illness" will be discussed in Dr. Lewy's paper.)

On the basis of experience and realization of previous mistakes, one might list the following principles of treatment of combat casualties:

1. *Early treatment*—as soon as the patient can be removed from the immediate stress; quick removal of a psychiatric casualty from his comrades, so that the patient's terror will not be contagious and disturb the general morale.

2. *Necessity of treatment of the physical condition*—fatigue, shock, etc. by rest, fluids, supportive medication, warmth and so on.

3. *Thoroughgoing psychotherapy*—not merely suggestion, or faradism to remove the acute symptoms, but eliciting expression of the underlying fears, and making the patient aware of the breakdown of his fear-controlling mechanism and of the advantages he seeks to gain by remaining ill. Such psychotherapy will also involve the patient's reliving of the traumatic experience, that is, overcoming of the amnesic defense against the intolerable experience.

4. *Base hospital care* only for actual psychoses and resistant cases of war neuroses.

5. Especial care should be taken to avoid diagnosing an organic case when it is of functional origin.

The type of psychotherapy to be employed will vary with the individual case. Anxiety cases can often be treated successfully with fairly superficial psychotherapy—suggestion, encouragement, rest, and a chance to discuss freely their fears and what they suppose is cowardice

in their breaking down. More severe anxiety states may require hypnosis or a combination of partial hypnosis and psychoanalytic abreaction, called by the British "hypno-analysis." In the first war and again in the present one, British psychiatrists have reported a high percentage of cures (about 90%) from the use of this method. It consists essentially of preliminary reassurance and friendly sympathy to establish rapport followed by the psychiatrist's using "forced recall" in attempting to get the patient to recall in detail, relive, and abreact the traumatic experience for which he is largely amnesic. This may be aided by the psychiatrist's placing his hand over the forehead of the patient and urging him persistently to remember more of the experience. This "assimilation" of what would otherwise remain a foreign body, an unconscious traumatic memory, is an essential step in recovery. This is followed by a discussion of how the symptoms and the amnesia resulted from the breakdown of the fear controlling mechanism, an analysis of the advantages unconsciously sought through the illness and re-education and rebuilding to a level sufficient to enable the patient again to resume the stress of fighting. Modern methods of warfare, involving extreme mobility, absence of any fixed lines, constant danger both behind the lines and even at home from enemy air attack, necessitate revision of the arrangement of field hospitals, base hospitals and discharge. However, ambulance transport planes can greatly shorten the time required to remove casualties to points where treatment can be given. Psychotherapy, being time consuming and individual, necessitates many psychiatrists in the armed forces. There are many other difficulties in the way of establishing ideal treatment methods, but if we are to avoid the astronomical expense involved in treating and compensating the psychiatric casualties of the first world war, these difficulties and handicaps must be overcome.

NEUROPSYCHIATRIC CASUALTIES AND COMPENSATION

By Ernest Lewy, M.D.

The claim for compensation for injury or sickness as a consequence of military service is based on the idea that the state, having placed the citizen in the situation in which he was injured or became ill, must therefore repair the damage, or where this is impossible, should compensate him for it and support him if he remains incapacitated. Usually, national laws provide that the injury or illness must have been incurred or aggravated in line of duty, to be considered service connected. A disability is also considered as service connected if identifiable symptoms of disease or injury are manifested sufficiently soon after the date of the claimant's discharge to suggest a probable relation to his service, if there is some notation in the official records of the army or navy that is confirmatory or suggestive, and if there is evidence of some continuity of the symptoms since the man left the service. But Congress has been very generous in this respect and has gradually permitted greater time intervals to elapse between the period of military service and the onset of the condition for which claims are made, so that now a presumption of service origin for neuropsychiatric disabilities manifested before January 1, 1925 (more than six years after Armistice Day) is permissible.

The presumption of soundness of the examinee at the time of induction (a presumption based on absence of notations of pathological findings in the examination records) can be used as a basis of a claim for compensation. This is especially important information for the examining physicians in the present emergency, since it shows the necessity for making careful notations of all abnormalities found at the time of induction.

On the assumption that many neuropsychiatric disturbances, including the psychoneuroses, are caused by constitutional factors, a few recent regulations have been made which diminish the obligation of the government to pay compensation. These provide that a man who breaks down within six months after induction with a major psychosis or with a psychoneurosis is not considered to have acquired this illness in line of duty. In case of war this time limit would be

reduced to three months. This is also true if there is "clear and unmistakable evidence that a disability had its inception before the period of active military or naval service." Nevertheless, service connection on the ground of aggravation can be conceded.

In many cases it is impossible to establish a certain causal connection between the military service and the illness for which the claim for compensation is made, chiefly due to a lack of scientific knowledge concerning the etiology of the conditions in question and the influence of external factors on them. In spite of this uncertainty and the consequent relative inadequacy of the governing ideas, it will be necessary to employ them since no better leading principles are available.

Present precautions directed toward the aim of eliminating at the start all persons liable to become neuropsychiatric casualties will not be sufficient. A large number of neurotic invalids is to be anticipated unless additional preventive steps are taken. It will be necessary to achieve this by applying to war neuroses the same measures that have been recommended for peace time accident neuroses, namely, *not to pay compensation for neurotic disturbances*, or at least to compensate them *with one lump sum only*. The continuous compensation provides a morbid incentive to remain ill and constitutes a powerful secondary gain of which the neurotic unconsciously takes advantage. This view is commonly recognized and corroborated by the scientifically founded view that all neuroses are purposeful reactions directed toward an aim and not of the same nature as common sicknesses, and although the compensation is not the primary motive of the illness, it supports this motive.

Furthermore, neuroses on the one hand and psychoses and organic sicknesses on the other are distinguished from each other in the following way: in organic sicknesses the personality of the person involved has ordinarily only a minor influence on the process of sickness; in psychoses the personality is too sick to be able to exert much influence on the condition; but in neuroses, the personality is sound enough and sufficiently in contact with reality as well as with the ill part of the personality to be able to exert some influence on the condition and to react in a fairly predictable way to outside influences. These two factors of the secondary gain and the tractability of neurotics not only form the causes for the establishment of chronic neurotic states but also provide the possibility of preventing this by eliminating

the external incentive for remaining ill. The state, which provides the premium for invalidism, bears a great responsibility for furthering a dependent irresponsible attitude which endangers public morale besides putting a great financial burden on the people. Thus the state has the moral duty to remove this detrimental cause by not providing continuing compensation. This needs to be done before the neurosis has had time to become permanent. Hence, diagnosis and decision as to compensation will have to be made with the utmost speed, and, simultaneously, adequate treatment must be begun.

The logical conclusions from the above mentioned points are:
1. Compensation should be allowed to all organic disabilities or to those where there is any probability of organic origin, and to all psychoses that last beyond the shock stage.

2. No compensation, or compensation by one lump sum only should be granted to all neurotic cases in order to prevent chronic neurotic invalidism and its detrimental moral and economic consequences.

THE REJECTED REGISTRANT IN THE COMMUNITY

By Douglass W. Orr, M.D.

The rejected registrant is a problem to himself, his family and his community. Whether a man is rejected by the Local Board, by the Induction Board, or by the Army a few weeks or months after induction, problems will arise (1) as a reaction to the *fact of being rejected*, for whatever reason; and (2) as a reaction to the specific *reason for rejection*, whether that be tuberculosis, mental deficiency, or whatever. In connection with the first, while many will take the fact of rejection as a cause for rejoicing, others will feel shame, loss of status, fear of accusations of disloyalty, and so on. The second set of problems will give rise principally to questions of what to do about the cause for rejection and how best to get it done. The services of the family doctor, a clinic or an institution may be required. Both in seeking medical care and in paying for it, if the registrant comes from a low or marginal income group, social agency assistance will often be needed.

Although it is known that about 35% of registrants called for training are being rejected, of which some 16% are for neuropsychiatric disorders, it is too soon to obtain accurate statistics on the incidence of particular problems. More to the point here are situations which involve a host of questions related to community resources, local and state laws, social agency procedures, and eligibility for assistance. First we may ask: What is known about the fate of rejected registrants?

One survey, made in Michigan, consisted of follow-up letters to Local Boards asking about the occupational status of 3,500 rejected registrants. The responses indicated that 84% of the men had been employed, mostly in unskilled occupations, before being examined; 16% had been unemployed, but only 3% of the total had been known to social agencies although 7% were vaguely reported on in this connection. In any event, 72% of the rejected men regained their employment after rejection, and 3% found new jobs. Thus 75% of the rejected men in this survey were rejected for reasons not incompatible with immediate re-employment. Of the remaining 25%, it must be assumed that some were unemployed, some returned to school or

college, and some were not accounted for because of inadequate information.

The fate of some rejected men may be explained by the discovery of previously unsuspected physical or mental disabilities or by reactions to the rejection itself or to the findings of the examinations. A few brief case records illustrate these possibilities:

(1) A Kansas boy was found to have active tuberculosis, and was, of course, rejected. Unable to afford private medical care, he became dependent upon social agencies. The specific problem has become one of residence: This boy has not lived long enough in one place for any community to have legal responsibility for his care.

(2) A young business man who had previously gotten along fairly well in his work was rejected by his Local Board examiner because of "irritable heart." Worry over this, reenforced by important unconscious factors, led to a frank neurosis for which he requires intensive psychotherapy. This he cannot finance without considerable help from relatives.

(3) A St. Louis clinic has already had eleven patients from men rejected for physical defects. One is the eldest of five children living at home. He was rejected because of tuberculosis, and is now hospitalized. Since his condition was previously unsuspected, the question now is whether some of his siblings also have tuberculosis.

But social, and perhaps psychiatric, problems may arise even if the reasons for rejection are not so serious. One source of difficulty lies in those situations in which a man is passed by the Local Board only to be rejected by the Army Induction Board. Such a man, between these two examinations, may have quit his job, made various business or family arrangements, had a number of farewell parties, or even married with the expectation of sending back at least a few dollars each month. Rejection at the Induction Center obviously may be very disrupting to the registrant and others.

Fortunately a remedy has been suggested for this situation. What started as an experiment in Pennsylvania may become a part of national Selective Service System policy. This plan calls for holding Local Board and Induction Board examinations at about the same time, but postponing actual induction into the Army for two or three weeks after the examinations. The registrant would thus know for sure that he will be inducted before he winds up his affairs and bids farewell to family and friends. As a protection to the Army, however, the find-

ings of the examinations stand *as if* done on the day of actual induction, so that it would avail a man nothing to get a venereal disease or other cause for deferment during the interim between examination and swearing in. This scheme, if made universal, should wipe out a very large proportion of the social and other maladjustment caused by rejection at the Induction Centers.

Another serious trouble lies in the lack of any uniform plan for informing the rejected man of the reasons for his rejection, on the one hand, with the likelihood, on the other, that he will read for himself what the physician's diagnosis has been. Often enough a man is told only that he has been rejected, and then is sent on his way. If, in addition, he has read the words "feebleminded" or "psychopathic personality" on the record, or if the family insists upon seeing the report, as they have the right to do, untold harm may result. It is apparent that rejected men or their families should be told the reasons for rejection, but in the right way and with suggestions, if wanted, for obtaining medical care.

Here again Pennsylvania has made valuable suggestions. Cases of tuberculosis and venereal disease are reported to the State Board of Health for follow-up and provision of treatment, while nervous and mental cases are similarly dealt with by the State Department of Welfare. Now, however, the Public Charities Association has proposed that, since the Selective Service System has in fact become a case-finding agency, the Local Boards must make it their duty to provide facilities through which every rejected man may be informed, in appropriate terms, of the reasons for rejection, the character of the disability, and the need for treatment. These men should than be urged to see their family doctors, or referred to a doctor or dentist as needed. If a man's economic status precludes private care, he should be advised as to what social agencies can assist him in obtaining necessary treatment. It is suggested that the cooperation of medical and dental societies be secured and that the giving of such assistance by the Local Boards be made mandatory in the interest of national health and preservation of morale.

As a final point, it is suggested that all rejected men be given opportunities, even though they return to jobs, for participation in civilian defense efforts. It has been shown in England that civilian workers, if given adequate training, can become efficient fire-fighters,

air-raid wardens, snuffers-out of incendiary bombs, and so on. Rejected registrants can find a supporting group in such activities and thus overcome any feelings of stigma at having been rejected. Beyond this, the relatively low incidence of neuropsychiatric casualties among civilians in Great Britain under the blitzkrieg has been attributed principally to the fact that everyone has been given a job to do and that everyone keeps busy while under attack. The public needs to be informed, too, that only men with special abilities and of certain personalities meet the requirements of a modern Army, and that those who do not happen to meet such requirements can serve just as usefully and patriotically, unless seriously disabled, in the Home Guards, in other Civilian Defense groups, or elsewhere on the "home front."

CIVILIAN MORALE IN TIME OF WAR AND PREPARATION FOR WAR

By Karl A. Menninger, M.D.*

From the positive standpoint, civilian morale means the maintenance of a spirit of optimism, courage, single-mindedness as to national aims, and loyalty to the government, the cause espoused by the government and the allies of the government. In times of war and in times of preparing for war national interests demand a part of the energy, loyalty, funds, and devotion which we ordinarily give to our own personal interests and good morale means that this sacrifice is made cheerfully.

From the negative standpoint, good morale means the avoidance of pathological emotional reactions on the part of people at large related to the threat of danger and the cost of the sacrifices necessary. Such reactions are fear, panic, pessimism, discouragement, suspiciousness, disgruntlement, resentment and the like. From the psychiatric standpoint, all of these reactions represent an inappropriate diversion or deflection to the nation itself of some of the aggression which should be directed against the enemy and the threat of danger. This phenomenon of substituting someone we love for the infliction of hate felt but unexpressed toward someone else is very familiar to psychiatrists. In individuals it is called neurotic; in a nation it is called disturbed morale.

I shall only mention some of the practical problems in civilian morale which impress me as being important. Among these I should list, first of all, the divided loyalties and confused aims incident to the Selective Service Act and its administration. It seems to be an unsettled question whether enlistment should be considered as primarily an opportunity for expressing unrestrained belligerency and brutality in a good cause; a privilege for the obtaining of vocational training, discipline, and companionship; an unpleasant patriotic obligation to be evaded if honorably possible; a course of discipline and treatment for reckless, wayward, spineless, unadjusted young male adults; or a course of punishment for recalcitrant individuals who need a firm hand.

* Also read at the Institute of Public Affairs, Charlottesville, Virginia, July 3, 1941.

As a matter of fact, registrants and Selective Service Boards seem to have no unanimity even among themselves as to which of these is primary. This is natural, I think. Army life at best is a very abnormal and regrettable necessity, and in our preparations for it, it is natural that we should be confused. The draft is a corollary necessity which has to be faced as courageously and expediently as possible. I think, however, that there is some advantage to morale in admitting our confusion rather than pretending a unanimity of attitude which does not exist. In this way it is more likely that unanimity will be achieved.

Similarly, there is in the minds of the members of the Selective Service Boards and their medical consultants considerable conflict as to whether their primary aim should be the development and improvement of the army, the welfare of the non-military citizens of the community, the consideration of the dependent wives and children of the registrants or the promotion of the best interests of the registrant himself.

Another aspect of this matter consists in a sort of double talk which prevails in regard to the Selective Service Act. We do not any of us like the draft but we know it is necessary and we do not like to admit our own hope that it will not affect us personally. Some individuals want very much to get into the army. Some want very much to stay out, but because it is unpatriotic and supposedly unmanly, cowardly, selfish, etc., to express very strongly any wish to escape the draft, such a wish is usually soft-pedalled. Those who want very much to get into the army include a great many whom the army does not want; those who wish to evade the army also include a great many whom the army does not want. Coming before the Selective Service Boards and the Medical Examination Boards, therefore, are certain individuals who cover up defects in order to get in and others who manufacture or exaggerate defects in order to keep out. The natural psychological tendency is for the Boards to do the opposite of what the pretender seeks, although this is neither logical nor desirable.

All of the experience and training of psychiatrists has been in the direction of promoting the best interests of the individual. Society and government have seldom called upon psychiatrists to offer advice or service for the best interests of the nation or the people at large. We have had some pretty definite opinions about how this might be

done but in the past we have been largely ignored. Public morale in this country appears to have been left to newspaper correspondents, politicians, columnists, radio commentators and the President himself. I think it is obvious that counsellors in civilian morale are needed by the government, and I believe that psychiatrists have something to offer.

Psychiatrists see as very serious problems in morale the divided loyalties in the hearts of individuals which arise in conflicting attitudes based on certain religious affiliations. These are troubling and sorrowful days for the Catholics who have been brutally persecuted by the Nazis, although this has not deterred certain Catholic leaders in this country from espousing the Nazi cause. Many persons have idealistic sympathy with Communism and pacificism who are not vicious, traitorous rascals but merely persons for whom these concepts have great emotional value which come into conflict with their patriotism. The mistreatment of these troubled and conflict-burdened individuals, no matter how provocative some of them become, destroys rather than builds morale. (Of course quislings and spies will often hide under the same cloak.)

Additional serious threats to our morale lie in the tendency of war and military organizations generally to widen the breach between the family and the state. Women feel this very keenly and a part of their opposition to war surely stems not so much from the fear of losing their sons by death as from the recognition that in war the army becomes more important than the home. The depreciation of the importance of women has a profound effect upon their psychology and is only countered by their strong identification with the male members of their families, supported by the hope that the conflict will soon be over and the normal status of family life re-established.

There is another problem which has been tacitly ignored in most of the articles I have read, although it is recognized to some extent by the service organizations and very keenly by psychiatrists. This is the disturbance in the normal sexuality and consequently in the moral pattern which is bound to result from the artificial segregation by themselves of several million young adult males for a year or more. Prostitution, promiscuity and homosexuality are all bound to be increased and the effect of these things will surely persist long after camps have been abandoned. The substitution of fighting for loving

is always a dangerous and unhealthy thing and the whole business of organizing and directing an army is, from the standpoint of the psychiatrist, bad mental hygiene. Now that it is a necessity, the first problem is to know how best to direct the sublimations and the control of the sexual life which are thus artificially disturbed. Under the best circumstances, the problem of sexuality in civilization is difficult. Under army conditions it is momentously so.

Finally, I would speak of the devastating effect upon the initiative, independence, ambitiousness, self-respect and psychological maturity of the young man who, dismissed from the army, is encouraged to believe that he has a right to be dependent upon the government indefinitely. In my opinion, the compensation, pension and other postwar reward systems inaugurated after the last war, costly as they were to the government, were far more costly to the morale of the citizenry. There are thousands of invalids in this country today who have been bribed by the government to remain ill but it is only fair to add that the government acted in this direction only under the pressure of predatorily directed sentimentalism on the part of persons ignorant of the bitter gift they were obtaining for their clients.

Let me come now to the more general aspects of morale—the problems that affect the thinking, the feeling and the very spirit of every one of us. Psychiatrists think of individuals as being driven by powerful instinctual forces which are *unconscious*. We have technical names for these forces and their variations in form, but let us avoid technicalities. War disturbs personal morale by arousing all of our primitive urges, and the tendency is for the negative ones to overwhelm the positive ones. No one, I suppose, would claim that war stimulates love in any considerable degree, although we do know that marriages and many constructive activities frequently accompany military preparation. But these positive effects are overshadowed by the powerful stimulation war gives to hate, to our destructive and self-destructive tendencies.

Why this war is particularly threatening in these respects can, I think, be derived directly from a consideration of present war philosophies. There is a conflict in political ideologies; the theory of oligarchically directed force with minimization of the importance of the individual and consequent passivity and blind compliance is opposed by what is called the democratic principle, which is a necessarily clumsy, inefficient, wasteful method of organizing social control

so as to permit as much freedom and responsibility to each individual as possible. Theoretically the intelligent benevolent tyranny (assuming that it can be kept benevolent) is far more efficient, more conservative of natural resources, more skillful in utilizing the products of intelligence for the direction of human activities, more powerful and closely knit an organization than a democracy ever can be. But we believe that the dangers of human corruptness in the uncontrolled leader outweigh these advantages overwhelmingly and we have a vivid example of this before our eyes.

Few Americans are likely to weaken in their intellectual agreement with this choice, insofar as they frankly face it. Many of them, however, are actually divided within themselves about it. Many idealists have no confidence in the ability of the "common herd" to agree about rules of their government. They believe that human weaknesses being what they are, the intelligence of the few is better than the stupidities of the many. Many industrialists believe this. Public Health Service, natural resource conservation and many other commendable things represent the principle of expert centralized control regulating the behavior of the masses for their own benefit. But this is not Fascism and even those who advocate more of it cannot fairly be called Nazis or Fascists. It must be recognized, however, that some people have distinctly divided loyalties and hence conflicts between their political philosophies and their recognition of the present practical necessities, and these conflicts are being exploited to the injury of morale by certain politicians, fanatics and paranoiacs who publicly extol the virtues of Nazi ideals.

There is a deeper emotional conflict which is aroused by war and by this war in particular. War appeals to people for the same reasons that the Fascistic philosophy appeals to people. It stimulates the wish to exert power over other people, to be aggressive, dominant, commanding, possessive. Civilization restricts such impulses in all of us only with great difficulty and when the program can be promoted, whether it is the Fascistic philosophy in Europe or the military organization in our own country which gives some individuals power over the lives and behavior of other people, it often attracts the wrong type of person to do this and creates envious ambitiousness of an unhealthy type in many people. Much as we talk about peace, all of us have secret yearnings, of which we are a little ashamed, to act in ways that would be permissible only if war existed. We want to

fight, we want to kill, we want to destroy; we want to control other people, and civilization forbids us to do this except in a righteous cause. War provides such a cause.

This, I think, is more important than the excitement, the novelty, the sporting element of contest, and all the other elements of glamor and romance in war which only those can feel who are not personally wounded by it. The thrill of working together in a common cause is a great satisfaction to many human beings and one which the competitive system of modern economics makes possible all too seldom. These are the temptations to the aggressive tendencies which war and and the preparation for war provide.

But there is a more subtle temptation, one which affects more people and one which is more corrupting. This is the temptation for the gratification of the latent passive tendencies. If the struggle with our aggressions is one of the great problems of each human being, the struggle with our passivity is certainly another. It is a great satisfaction to certain deep, unconscious urges to be able to relegate authority to someone else, to submit meekly to what one is told to do and to expect in payment for this obedience protection, patronage, praise, pay and all the other humiliating "p's." It is comfortable to many individuals to be able to lay aside the responsibilities of maturity, not voluntarily, but by official decree and to resume a childlike relationship to an authority comparable to that of the parents. But this authority must not only command us and use us, it must reward us and it must support us. It is a continuation of this tendency that I referred to in regard to the post-war problems of pensioning, compensating, hospitalizing, etc., so destructive to mental and spiritual health. Thus war and preparations for war arouse two repressed tendencies within us, destructive aggressiveness and dependent passivity, tendencies which all civilization, all psychological growth, all social maturity oppose.

I do not apologize for having called your attention to these serious threats to our national morale. I am convinced that only by recognizing their existence can we properly deal with such problems. Treatment and prophylaxis can only be based upon an understanding of disease. But I shall conclude with certain positive and encouraging aspects.

A practical program for morale should be based on how best to minister to the pathological tendencies of human beings about to be

trained for battle and led into battle as well as those who remain at home wishing that they could be given a similar opportunity. For this we have three great resources; play, work and knowledge. To recognize the dignity of *recreation* and to make it possible for those who are now forced into abnormal life situations to absorb some of their energies in constructive play is not a mere ornament or side issue to be supplied by religious organizations or charitably inclined individuals but a fundamental necessity for the morale of the nation.

Work that contributes to the common purpose, on the other hand, while well provided for in most well directed army camps is still sadly lacking for civilians. People want to feel that they are doing something for the cause, that they are a part of the great movement, that they too are standing shoulder to shoulder with the soldier and the statesman. The organization of activities for women, for the men who are not drafted, for the young men not suitable for the army, and even for the children is more than desirable encouragement of patriotic feelings. It is an antidote against fear, discouragement, suspicion and resentment. Useful action and vigorous preparation to meet danger will develop the strength of a common purpose in a way which will make the united support of central leadership far more unified and effective. The splendid morale in Britain during the past year is eloquent testimony to the validity of this statement.

And, finally there is the antidote (against poisoned morale) of *knowledge*. I mean by knowledge the application by experts of their specific knowledge to problems of personality within the army, within the community, within the state department if necessary! I mean not only the knowledge of psychiatrists, however; I mean the knowledge of all those who have intellectual contributions to make to the national purpose. I further mean knowledge supplied by the government to the thoughtful members of the body politic, honestly, clearly and promptly. I mean a proper explanation of and warning against the subtlety and wide extent of enemy propaganda. Confidence is not inspired by admonitions, by disapproval, or by coercion and it is easily undermined by deception. If you want to encourage a child to be brave, says Glover in a recent book on morale, *The Psychology of Fear and Courage*, you "do not begin by telling him that he is silly; you encourage his sense of responsibility, give him something sensible and useful to do, show him a good example, *tell him the truth*, *admit your own errors*, and be friendly with him. He will do the rest himself."

PUBLICATIONS BY MEMBERS OF THE STAFF

R. W. Robb, Benjamin Kovitz, and David Rapaport. Histamine in the Treatment of Psychosis. *Am. J. of Psychiatry*, 97:601–610, November, 1940.

Histamine was administered to a group of catatonic patients in increasing sub-shock doses. The patients were tested with the Rorschach Ink Blot Test before and after the histamine treatment. A comparison of the test findings with clinical observations showed that the two were in good agreement and that the test indications of improvement were similar to those found in tests of metrazol-treated catatonics. Reference is made to the fact that the improvement of circular psychotics is indicated in the test by diametrically opposite indications. The possibility is suggested that the effect of drug therapies in psychoses depends to a great extent on the type of psychosis treated rather than on the kind of drug used.

Brown, J. F. The Position of Psychoanalysis in the Science of Society. *J. Ab. & Soc. Psychol.*, 35:29–44, January, 1940.

This is one of a series of ten papers by analyzed psychologists. Psychoanalysis is separately discussed as a method of psychological observation, a systematic set of theoretical constructs, and as a psychotherapy. Closer cooperation between psychoanalysts and psychologists is suggested, because, although psychoanalysis represents the most important contemporary contribution of psychology, it still needs methodological clarification and criticism.

Brown, J. F. Freud's Influence on American Psychology. *Psychoanalytic Quart.*, 9:283–292, April, 1940.

This paper, written as a contribution to a memorial issue on Freud, reviews historically the influence of psychoanalysis on academic psychology, discusses its present influence, and attempts to predict its future influence. Its influence, which was originally inconsiderable, is at present great and will undoubtedly be even greater in the future.

Brown, J. F. Freud's Contributions to Psychology. *Am. J. Orthopsychiatry*, 10:866–868. October, 1940.

This paper attempts to evaluate Freud's contributions to the permanent body of psychological method and knowledge. The method of psychoanalysis and many factual findings undoubtedly belong there. On the other hand certain of the theoretical constructs will appear if at all, in a modified form.

BOOK NOTICES

Great Experiments in Psychology. By HENRY E. GARRETT. Price $2.50. Pp. 430. New York, D. Appleton-Century Co., 1941. Revised edition.

This revision brings Professor Garrett's useful, historically and anecdotally annotated introduction to the laboratory psychology of the universities up to date. By adding new material and references the old plan of the work is followed, with the exception of a new chapter on personality. Most psychiatrists and all psychoanalysts will find this chapter inadequate. (J. F. B.)

The Human Enterprise. By MAX OTTO. Price $2.25. Pp. 385. New York, F. S. Crofts & Co., 1940.

This is a group of philosophical essays on the conventional philosophical topics of man, science, reality, and God, written in a delectable style. The author invokes the importance of the "human enterprise" in terms of respect for personality. Most scientists, like the reviewer, will probably find it difficult reading. (K. A. M.)

The Adolescent Personality. By PETER BLOS. Price $3.00. Pp. 517. New York-London, D. Appleton Century Co., 1941.

By comparing the observations and comments of teachers from the early grades through high school with actual productions of the child at various ages and in personal interviews with himself, the author relates the adjustment difficulties of four adolescent cases to emotional conflicts of fairly standard types. The material is presented in a clear, well-organized, somewhat repetitious and pedantic fashion, which should make it very useful to teachers seeking to gain or to impart a better understanding of adolescent behavior. (K. A. M.)

The Secret of Childhood. By MARIA MONTESSORI. Translated and edited by BARBARA BARCLAY CARTER. Price $2.50. Pp. 286. New York, Frederick A. Stokes Co., Inc., 1939.

Marie Montessori introduces a crusade for better understanding of child development and education on the part of parents and teachers. She discards psychoanalysis as being unable to contribute an understanding to the development of a normal child, aside from the fact that psychoanalysis has shown the importance of infantile traumata on later adult adjustment. Her plea that the child be considered an individual and that there be less domination of him by his parents and teachers is a worthy subject; her development of the theme is less valuable. The most interesting section of the book is that part in which she describes her own method of education for children. (A. R. B.)